Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier U 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Evelyn Mae Brittain ,2010 0135 116 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Salisburg Rehabilitationa Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In vrs. last birthda Wicomico Sbur If Under 2) Hrs. 8. Date of Birth (Month, Day, Year) July 2,1924 9. Birthplace (State or Foreign Country) New York **Funeral** Days 1 □ M 2 🗓 F Months Hours 86 115-18-8397 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show must be notified at 1 ☐ Yes 2X No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code with ò 21804 USA 200 Civic Avenue 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or item
any injury or other traumatic event, the Medical Existint Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aeronautical Engineer Government Contract 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Nutter George Brittain ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7209 Opal Circle, Hebron, Maryland 21830 George B. Norcross/Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Crematory Of Delmarva 7/22/2010 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 3171
1212 Old Ocean City Road, Salisbury, MD 21802 21. Signeture of Funeral Service Deneu Approximate Interval Between Onset and Death Poil 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List buy on a loss on each list. Immediate Cause (Final Physician 90an disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ilan. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 □Yes 2 □No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of Pertifie 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar William H. Robins

DHMH 17 Rev 1/2001

M.D. 200 C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July Physician/ 2:00P M Katherine Bishop 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 513 Arbor Drive Glen Burnie Anne Arundel 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year **Funeral** Days Dec. 26 1 🗆 M 2 🕱 F 1928 81 Virginia 215-26-6019 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Glen Burnie Anne Arundel 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21061 513 Arbor Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. Maryland 21215-0036 Š 1 Never Married 2 Married Yes 2 X No Specify white Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) electronics line supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Audie Elizabeth Newcomb William Irvin Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 513 Arbor Drive, Glen Burnie, MD James M. Bishop Sr. husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Mardela Springs, MD 7/23/10 Mardela Springs Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee Cambridge, MD 700 Locust St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence Examiner LRIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed e percholestero fema Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerformed' death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) title of certifier 29d. Date signed (Month, Day, Year) 29b. Signatur 31122 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Doyle 1417 Made Son Park Drive

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per phys. G906 8/19/10 dk

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:48 AM Georgia Elizabeth Burnett-Williams 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Feb. 19 215-26-8667 Year 1928 West Virginia 82 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the M. dical Examiner must be notified at Director Marvland Washington County Hagerstown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a U.S.A. 1305 Cedarwood Dr. 21742 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) State Government Nutrition Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Mary Russ Lewis David Ernest Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other traw 12903 Little Hayden Circle Hagerstown, MD 21742 Elaine Lewis-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 7-31-2010 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease; of comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ Kumonia disease or condition Medical resulting in death) Due to (or as a consequence of) 12 days Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☑ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the sahould be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy aletes 1 Yes 2 No Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifliceted filled in by the funeral director, of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) lospital: 2 🗷 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? iniury Natural 5 Pending Division 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-5 MILL ST. HAGERSTONN, MD 21742 RANCISCO 350 AMORADE JUL 27 State Registrar

Recharge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010^{ar} July Bransfield 9:30 A M Evelyn Warner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 405 Clay Hammond Road Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Hours New Jersey 06-19-1920 90 Director 158-10-5206 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 🔀 No Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 405 Clay Hammond Road 20678 USA hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🕅 No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry pernit, Page 1 and 2 should be filed within 72 h
Der artment of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Warner Evelyn Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Bransfield, son 405 Clay Hammond Road, Prince Frederick, MD 20678 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Metropolitan Crematory 7-23-2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Heart Failure Immediate Cause (Final Onset and Death Conq Physician/ disease or condition resulting in death) Medical Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) sician and burial-transit Exami Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day cate has been signed by the page 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aorhic Stanesis, Chronic Athia I hould be 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 or Attending Physician: The 2 🗆 No this certificate 1 Yes After this certification of the funeral director, I 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural s after dec. ral Director: After 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be To the Hospital or Atte within 24 hours after de:
To the Funeral Director completed filled in by th ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) INTERNIST Sicloliqui. DSGSIBB 07/22/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL ROAD PRINCE FREDERICK MD 130 SHAHID SIDDIEUI MD 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-05433 State of Maryland / Department of Health and Mental Hygiene James Barry Bussink Certificate of Death 1- For State Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 0050 hrs July 21, 2010 Medical Examiner James Barry Bussink 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 9. Birthplace (State or Date of Birth(MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) CA Months Days Hours Min Director 05/23/1964 46 1 X M 2 F 551-53-1239 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 X No 28a-f show Lusby more, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If teen 27 is marked other than "natural", or items 23a or 28a-f show or other trannatic event, the Medical Examiner must be notified at once. MD Calvert 10g. Citizen of What Country' 10f. Zip Code 10e. Street and Number 20657 U.S.A. 3094 Lighthouse Blvd 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married 1 Never Married Yes White If Yes, Give Year Yes 2 X No specify. Specify 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NDT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Local Union 99 Building Engineer 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Janet Bertha Nickerson John Bernard Bussink Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3094 Lighthouse Blvd., Lusby, MD 20657 Sharon Bussink/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Silver Spring, MD Gate of Heaven Cemete**r**y vartment o Donation 5 Other Specify 22. Name and Address of Facility of Funeral 5 Lee Funeral Home Calvert, P.A. 18125 Southern Md Blvd., Owings, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lisa M Approximate Interval Physician een Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED the attending physician ed for use as the burial -UNPENDED Records, P.O. Box 68760, The law requires that the death certificate be e 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown ğ Diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital æ Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27 Manner of Death Certification within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 V Natural 1 Yes 2 No Pendina 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and title of certifier

Carol Allan, MD

31. Date filed (Month, Day, Year)

32 Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 21, 2010

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 10 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 40 Month Year James Edward Brady, Jr. 21 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Calvert 810 White Sands Drive Lusby 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year Days Maryland 1 🛛 M 2 🗆 F 40 Nov. 6, 1969 212-90-5910 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20657 United States 810 White Sands Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 15 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mechanic/Tile Setter Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James E. Brady, Sr. Alice Moreland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michelle Brady / Wife 810 White Sands Drive, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 107/22/2010 Lee Crematory Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Juneral Service Licenses 8125 Southern Maryland Blvd., Owings, Md 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence off any, leading to infinedecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Examiner P.O. Box 68760. Division of Vital Records,

the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran signed by the attending l use this certificate has been sal director, page 2 should funeral director, After ours after death.
seral Director: Af within 24 hours a completely 2

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

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Completed

Item 27 is marked other than "natural", or Items 23a or 28a-f shor other traumatic event, the Neglical Exporter must be recitived at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any inlury or other traumatic event, the Madical Exercisions.

Physician

/Medical

Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

IF FEMALE:

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Prince Fred. MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Merri mac 238

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Arlene Byrd		State of Maryland / Department of He 1- For State Certificate of De- Registrar			2010	24507
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the Ma Sa or 28 otified	Director		1801		JSA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Yes, sp	edent of Hispanic Origin? (Sprecify Cuban, Mexican, Puerto I		White, etc.	ican Indian, Black,
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21215-0036 Suld be filed within 7 Mental Hygiene. In marked other than ic event, the Medica	å	Charles H. Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	Arlena ess (Street and Number or R	M. Hol	_Mes_ per, City or Town, State	. Zip Code)
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Baltimore, permit. Pages I as Department of He Important: If ite	-	4 Donation 5 Other Specify: Spring Hill 21 Signature of Fund of Societationsee 22. Name a	and Address of Facility Q1		Hebron,	
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Physician /M_cical Examiner	4	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	, ,	, ,		Between Onset and Death
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isior r Attend er death rrector:	Certification:	Accident Jul 18, 2010 1904 hrs Jul 18, 2010 1904 hrs	tory, office building, etc.	28f. Location (St	treet and Number or Ru	ral Route Number, City
Div spital or nours aft neral Di filled in	5 5	4 Homicide determined (Specify) Multi-Family Apt.		-	ate) urt Apt 303, Salisbur	
Division of Vital Records, P. (To the Hospital or Attending Physician: The law requires tha within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be det	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at and manner stated.	the time, date and place, and my opinion, death occurred a	due to the cause t the time, date a	e(s) and manner as stat nd place, and due to the	ed. le cause(s)
F. 3 F. 8	¥		29c. License number		29d. Date signed (Mo	nth, Day, Year)
7	-	30. Narge and address of person who completed cause of death (Item 23a)	O.C.M.E.		July 19, 2010	
4M		Pamela E. Southall, MD Assistant Medical Examiner 111 Pe	nn Street, Baltimore, M	1D 21201		
Sta Registra		31. Date filed (Month, Day, Year) JUL 2 2 2010 32. Registrar's Signature	/			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 24508 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ MADE 910P M 2010 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner If Under 24 Hrs Hours Min. If Unde 8. Date of Birth g. Birthplace (State or **Funeral** Months Days 1 ☐ M 2 🖳 F (Month, Day, Year) Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location the Maryland 10d. Inside City Limits Director Wicomico MARULANEL Alsbury 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 510 2180 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 호 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No If Yes, Give Specify. BIACK Completed 3 - Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha NONE Domesti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JACKSON HARRISON URIS Ache 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EYGENE 410 FlowER BERLIN MARULAND SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or ACRES 4 Donation 5 Other (Specify) GREEN 25 of Funeral Service Li Name and Address of Facility Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Priysiciani acute disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 5e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work? Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 3085 0 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsu Ilvia MO Sa/155600 JVI

DHMH 17 Rev 7/2009

State Registrar Begistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 1800 Henry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICE TENIN SYLA Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Mrs 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Funeral 1 M 2 X F Country) Director 258 20-3090 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21853 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗷 No 1 Never Married 2 Married 1 Yes 2 Completed by 21215-0036 1 Yes 2 No Specify: Specify: Plack 3 ₩idowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) cubora Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) Doughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betti Princes Hawkins Harris Ann Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Princess Anne 4 Donation 5 Other (Specify) ale 12010 22. Name and Address of Facility 30479 Prince Williams A Funda Service Lice Smith tuneral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pmysician/ Acute disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant
9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 Probably 4 chiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 87-20-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUSbyley 31. Date filed (Month, Day 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			5. Social Security Number 6. S	ex 7. Age (ir	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day	Year)	9. Birth Cou	place (State or Foreign
	eral ector		230-70-6497	2 F 6	Yrs.	Months Days	Hours Min.	Jan. 31	, 19		ginia
pu »		-	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City Limits
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with	t be r		69 Confederate Wa	ay		22554			USA		
death	L mus	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r în U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- Rican, etc.)	14	. Race - Amer Black, White	
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should Me	matic	၉	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street	and Number or R	ural Route Numb	er, City or	Town, State, Z	ip Code)
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of Her	othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, crea	osition (Name of matory or other place	ce)	Date	20c. Loc	ation - City or	Town, State
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partimore, permit. Pages 1 a Department of Hee	any inj		21. Signature of Funeral Service Licen	see H	1.141	2. Name and Address 801 Jeffe	Cov	enant Fu	mera	1 Serv	ice
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the lithin 2	mple	Medical	29b. Signature and title of certifier	and manner state		29c. Licens	se number		29d. Date	signed (Mon	th, Day, Year)
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			30. Name and address of person who							1	
			11.01.00	masopon			600	North Wo	olfe Si	, Baltim	ore, MD, 21287
	Sta		31. Date filed (Month, Day,	0 5 2010 Registra	Signature	bonde	B				

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State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0325M Yu Ing Cheung 2010 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6902 Rodenia Road Prince George's Camp Spring If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 M 2 XXF June 28, Year) 578 92 2329 77 China Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 ⋤ No Maryland Prince George Camp Springs 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6902 Rodenia Road 20748 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married XXX Married þ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Chinese "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) If Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) n/a Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Siu Loong Cheung (Daughter) 1308 McLean Crest Court McLean. Va 22101 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 Donation 5 Other (Specify) Fort Lincoln Cemetery fulv 19, 2010 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria f Funeral e de Li Signetur m00257 Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death AsphyxiATion Immediate Cause (Final Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any lieding to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to or as a consequence of death certificate be executed the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE: for use 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed I page 2 should be dete 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No Physician: Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ 28a. Date of injury
Found: Day, Year)

28b. Time of Found: Wor Unknown M 1 L

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) this 28d. Describe how injury occurred H Division of completed filled in by the funeral 27. Manner of Death Certificate: 28c. Injury at 24 hours after death. Funeral Director: After I Hospital or Attending 1 Natural 5 Pending top stouch from 1 Yes Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6902 Rodenia Rd., Camp Springs, MD 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner To the best of my knowledge, death accurately diet the time, date and place, and due to this basisies) and manner as stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUL 2 U 2010 Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ July Francis Paul Cardaci 19 7:03 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 . F Months Hours (Month, Day, Year Sept 22 New York Director 1936 220-32-6637 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 2000 Tundra Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Ď Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. should be filed with and Mental Hygien is marked other th 5+ Professor University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hilda M. McLendon Francis Paul Cardaci, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 2000 Tundra Court Annapolis, MD 21401 Hildegard Cardaci/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Final Journey Crematory 07/22/10 Woodbine, MD 21. Signate of Funeral Service Licenses Golffigar Hoffes Cremation Service P.O. Box 784 21029 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition Onset and Death Physician neumonia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Ď in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year ned by the a detached f Yes 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ₩ page 2 : autopsy performe Yes 2 K No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After e Hospium 124 hours after death.
he Funeral Director: After a in by the fur 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 46052 30. Name and address of of death (Item 23a) (Type, Print) edical Parlway ana tolos typ 10 31. Date filed (Month, Day, Y State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 19e State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 7/28/10 per FH Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician/ 2/31 PM ose } JUL 2010 ee hae Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** poton Hapers town HOSPita Count 0 inz Jashinpton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of L. (Month, Day) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1<u>962</u> Mary Land Months Days Hours 1 XM 2 □ F 218-50-3712 48 June Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland al Hygiene. at Hygiene. d other than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2X No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16237 Wishard Rd. 21740 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Organist Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item Z7 is marked o any injury or other traumatic eve any injury or other traumatic eve Peggy Jane Foltz Cosev Harry Lee Cosey 19a. Informant's Name/Relationship (Type, Print)
Beth Anne Cosey - Wife
Karen Anne Cosey wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16237 Wishard Rd. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 7-28-2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service License Eastern Blvd. North Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Physician Sta ongesty disease or condition Medica resulting in death) Examine schemi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has funeral director, page 2 performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ျှ 2 No 1 🖄 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0068 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-4 HOSPita eyene 31. Date filed (Month, Par, gistrar's Signature 32. State

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Registrar

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Physicia Medic		Kathleen Virg								July	<u> 15</u>		2010	3:00	P M
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Formula		Shady Grove H	ospital 6. Sex	7, Age (In yrs. I	ast birthday)		ckvi	If Under	24 Hrs.	8. Date of Bir	rth	MOII	gome 9. Birtl	nplace (State	or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The protect it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. County							10d. Inside	City Limits					
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Physician/		shock, heart failure List Immediate C e (Final disease or condition	only one cause on ea	ach line. YSTOL										Interval B Onset an	
Medical Examiner		resulting in death) a. Due to (or as a consequence of):													
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l or Atte after de Directo	Certificate;	3 Suicide 6 Could 4 Homicide deteri	mined 28e, Place	e of Injury - At h ling, etc. (Specii		eet, facto	ry, office			28f. Location City or To			ber or Ru	ral Route Nu	mber,
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin Equations after death within Equations after death and the Futhorius after death this certificate has been signed by the attending physician to complete filled in by the funeral director, page 2 should be detached for use as the buriance of the complete filled in by the funeral director, page 2 should be detached for use as the buriance of the complete filled in by the funeral director, page 2 should be detached for use as the buriance of the complete filled in by the funeral director, page 2 should be detached for use as the buriance of the complete filled in by the funeral director, page 2 should be detached for use as the buriance of the complete filled in by the funeral director, page 2 should be detached for use as the purious complete filled in by the funeral director, page 3 should be detached for use as the purious complete filled in by the funeral director, page 3 should be detached for use as the purious complete filled in by the funeral director, page 3 should be detached for use as the purious complete filled in by the funeral director, page 3 should be detached for use as the purious complete filled in by the funeral director, page 3 should be detached for use as the purious complete filled in by the funeral director, page 3 should be detached for the filled in the filled in by the funeral director and the filled in the filled	Medical	(Check 2 Medical	ng Physician: To the Examiner: On the ba	sis of examination	on and/or inves	tigation, i	n my opinio	n, death o	occurred	at the time, date	and place	ce, and c	due to the	cause(s) and	manner stated
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		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type I	Print)									
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State

Registrar

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

~2 1 2010

Patricia Aronica-Pollak MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:45 AM Paul P. Dano 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HOSP.to Agnes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F 126-44-2848 Director June 1, 1944 Slovakia 66 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 2934 Rosemar Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Engineer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Dano Helena Komanova ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie C. de Verneil/ 2934 Rosemar Drive Ellicott City, MD 21043 Partner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 07/23/10 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Jano, Pan (Division of Vital Records, P.O. Box 68760, signed by the attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? leukemi 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy After this certificate 2 XNo 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) myssel Wang, July 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Ming-Hsi 900 Caton Ave Wang Battimore, MD 21229 JUL 23 2010 32. Registrar's Signature 31. Date filed (Month, State Registrar parke

10-05306 Roland Emory Di	ıı <u>Aı</u> ller	nended Please Tyr Per St	pe or Print in are of Maryla	Black Ir	ndelible artment o	Ink. Ensu	ure All C	opies Are L e al Hygiene	egible	e.	0 01515
		l- For State Registrar		Ce	rtificate (of Death			Reg. No.	201	0 24517
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		4a. Facility Name (if not institution 1320 Weverton Road	n, give street and nur	mber)		Knoxville	, or Location of	r Death		County of Deal Vashington	ın
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 '	Year If Under	24Hrs. 8. Date of I	Birth(MM/	Forei	rthplace (State or ign
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, any		10a. State 10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limits
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he Mar 1 or 28s	Director	1320 Weverton	Road			,	.758			ited Sta	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status		edent Ever in U		/as Decedent of	Hispanic Origi	in? (Specify Yes or I Puerto Rican, etc.)			rican Indian, Black,
ter deat	Fun		1 X Yes orced If Yes, Give Year	2 No	1	Yes 2 X	No specify:			Specify: W	nite
ours af	ad by	15. Decedent's Education (Spe			16a. Deced	ent's Usual Occu		ind of work done	16b. k	Kind of Business	
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215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica		17. Father's Name (First, Middle,	Last)		0.0	15 Deac	18.Mother's	s Name (First, Middle			
2121 uld be f Mental marked c event,	To Be	Charles E. Dil	ler hip (Type, Print)		19b. Maili	ng Address (S		e Kessler ber or Rural Route N	umber, Ci	ity or Town, Stat	e, Zip Code)
MD d 2 sho lith and m 27 is	-	Charles E. Dil	ler/ Son								yland 21701
Ore, ses 1 an of Hea If iter		20a. Method of Disposition 1 X Burial 2 Cremation	Removal fro	m State	crematory or			Date		Location - City o	,
Baltimore, permit. Pages I a Department of the Important: If ite		4 Donation 5 Other Sp 21. Signature Funeral Service		Mt				7/22/2010 1 Homes P		ederick	, Maryland.
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Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each lipe.	sused the death	n. Do not enter	the mode of dyi	ng, such as ca	rdiac or respiratory a	arrest, sho	ock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hanging Due to (or as a	consequence of	of):						
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	of):						
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Box 68760, e death certificate be exe the attending physician a ed for use as the burial -	ian/N	23b. Was decedent pregnant in the past 12 months?	1 Live bi		2 F	etal death	3 Ectopic	pregnancy	250		Day Year
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O. मूं कृष्	b P	Part II. Other significant condit	ions contributing to	death but not i	resulting in the	underlying cau	se given in Par				the cause of death?
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Divis al or At s after d I Direct	rtific	3 Suicide 6 Coul	d not be 28e. Place		ome, farm, str	eet, factory, offic	ce building, etc.	or Town	State)		ural Route Number, City
Division of To the Hospital or Attending Phymin 24 hours after death. To the Funeral Director: After teempletely filled in by the funeral		4 Homicide	nysician: To the best	Woods of my knowled	ige, death occ	urred at the time	, date and plac			id, Knoxville, N id manner as sta	
To the within To the complet	Medical	one) 2 Medical Exa	miner: On the basis o and manner st		and/or investig			urred at the time, da			
	≥	29b. Signature and title of certifie	11. 11 . 2 . 4)			ense number C.M.E.			Date signed <i>(Mo</i>	οπτή, Day, Year)
	-	30. Name and address of person	who completed cause	e of death (Iten	n 23a)					-	
(Pamela E. Southall, M		Medical Exa			eet, Baltimo	ore, MD 21201			
Sta		31. Date filed (Month, Day, Year)	2010 32.00	gistrar's Signat Sid-Mark	A. So	arked					

Judith B. Downey Baltimore, Maryland 21215-0036

			State Registrar	State of Mary	,	ertifica				eg. No.2 0	10	24518
	Physicia	an	1. Decedent's Name (First, Middle, Last)						Month	Day	Year	12:30 PM
-	/Medic	al	Judith Burdick Down 4a. Facility Name (If not institution, give str			4h City	, Town or	Location of Death	July	4c. County	(0.0	18100 4
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	Funeral		5. Social Security Number 6. Sex	7. Age (/	In yrs. last birthd	If Unde	er 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,			ice (State or Foreign
	Director		119-26-7265	M 2 X F	78 Yrs	Months	Days	Hours Min.	June 10	1 932	New Y	
	р		Usual Residence of Decedent		0 Oil T							d. Inside City Limits
	arylar show	-	10a. State 10b. County		Oc. City, Town or						100	1 □ Yes 2 No
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	with th	Ē	10e. Street and Number		20	101. 2	ip Code	0				y:
	sath is 23	eral	19800 Tranquility (J Lr. APT Z 2. Was Decedent Eve		3. Was Dec	2174.		ecify Yes or No-	U.S.A	e - America	n Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilh and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Ever inter must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1. ∑Yes 2 □ No If Yes, Give Year or Dates:		If Yes, sp 1 □ Yes		lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ck, White, et v: Whit	
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	f Hea		20a. Method of Disposition		20b. Place of Di	sposition (N	ame of	ol ol br.	Date	20c. Location -	City or Tov	vn, State
9	Pages ent o nt: If i		1 ☐ Burial 2 🖾 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Smithsh	nama C	romat	ory 7-26	-2010 s	mi thebu	ra M	arvland
Baltimore,	mit. I	1	21. Signature of Funeral Service Licensee	- 0	, I I	22. Name	and Addre	ss of Facility Do	uglas A.	Fierv	Funer	al Home
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Division of Vital Records,	Attending r death. ector: After by the funer	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm	, street, facto	ory, office		28f. Location (S		ber or Rura	Route Number,
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	e Hospital or Attendi 124 hours after death e Funeral Director: A pletely filled in by the fi		29a. Certifier 1 → ertifying Phys. (Check only 2 → Medical Examin	cian: To the best of er: On the basis of e	my knowledge, o	leath occurr	ed at the t	ime, date and place	e, and due to the our	cause(s) and m	nanner as st and due to	tated. the cause(s)
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ن	H 5+1		30. Name and address of per on who cor	npieted cause of dea	ın (item 23a) (Ty 7 🔏 😢	pe, Print)	100	28365 Stut	Hace	Keyan	MA	2 /2/.8
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month therine Donnal 2)11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomer Brooke Grove Rehabilitation and Nursing If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 82 vrs **Funeral** 1 🗆 M 2 🗀 F Days Fe/190th, Pay, Year 1928 Hours Min 126-22-5056 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Examiner must be notified MD Rockville 1 ☐ Yes 2 🔀 🖔 Montgomery 5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 16401 Hillcroft Drive 23a Funeral 20853 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 9 þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: White "natural" Completed 3 Midowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vincent Edward Sutliff Katherine Kubler 19a. Informant's Name/Relationship (Type, Print) Margaret D. Crivella/Daughter 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zio Codel 16401 Hillcroft Drive, Rockville, MD 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Mount St. Mary S Cemetery 1 Hurial 2 ☐ Cremation 3 🖾 Removal from State July 23 4 ☐ Donation 5 ☐ Other (Specify) Flushing, New York 21. Signature of Funeral Service Lie 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease Immediate Cause (Final Physician malignant ears disease or condition Medical resulting in death) Due to (a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

"Ve the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the buring the state of the page 2 should be detached for use as the buring the state of the page 2 should be detached for use as the buring the state of the page 2 should be detached for use as the buring the page 2 should be detached for use as the buring the page 2 should be detached for the page 2. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner' Hospital Other: 2/1 No ျပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation M 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie up attending Physician

State Registrar Brooke Huffman

2010

31. Date filed (Month, Day, Year)

18100 Slade

M.D.

Registrar's Signat

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last)				Date of Death Month	201	<u> </u>	3. Time of Death
	Physicia Medic		Benito DiLuccia				July 19	, 2010	ear	7:35 am
_	Examin	er	4a. Facility Name (if not institution, give street and numbe Suburban Hospital	7)	4b. City, Town, or Bethe	Location of Death		4c. County of I		rv
*	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9	. Birthol	ace (State or Foreign
	Director		578-70-0505 XXM 2 F	74 Yrs.	Working Buys	Tiours Will.	July 3,	1936	Ιt	aly
	and show	٥	10a. State 10b. County	10c. City, Town or Lo	cation				10	d. Inside City Limits
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	ath wi	Funeral Director	8804 Connecticut Avenue	nt Ever in U.S. 13.	Was Decedent of Hi	0815 ispanic Origin? (Spe n, Mexican, Puerto	cify Yes or No-	USA 14. Race - A	America	n Indian,
030	be filed within 72 hours after death with the Maryland ental Hygiene. Age other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show the other than "natural Examiner must be notified at ite event, the Medical Examiner must be notified at	þ	Armed Force 1 □ Never Married XX Married 3 □ Widowed 4 □ Divorced Armed Force 1 □ Yes 2 If Yes, Give Year or Dates	Black, V Specify: W	White, et hite					
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מפ	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)	-1		18. Mother's Name	e (First, Middle, Ma			
Maryland	uld be I Ment narke	욘	Giovanni DiLuccia				eppa Mont			
	1 and 2 should be filed within 72 hours the Bath and Mental Hygiene. It marked other than "natur other traumatic event, the Medical I		19a. Informant's Name/Relationship (Type, Print) Mary DiLuccia/Wife			and Number or Rura icut Aver				
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other plac itan Crem	e) i "Tı	11y 24,	oc. Location - Cit	•	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	2; F 5	2. Name and Addres rancis J. 00 Univer	ss of Facility Collins Sity Blvd	Funeral	Home Inc. 1ver Sp	c. rinc	, Md 20901
			23a. Part 1. Letter the disease, or complications that can shock, of heart failure. List only one cause on each	d the death. Do not ent						Approximate Interval Between
	nysician/	i q	Immediate Cause (Final disease or condition resulting in death)	gnam f	trten	Disec	ree			Onset and Death
	⊦ Medical Examiner		Due to (or	as a consequence 16):		,				
	^	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of):						
	physician and the purish transit	Examiner	Cause (Disease or linjury that initiated events c.	as a consequence of):					+	
	ate be execute ohysician and the burial-trans	sal E	resulting in death) Last Due to (or	as a consequence oi).						
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Box 68	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as 00711 AM	Physician/M		th 2 Tetal death 3 to the string of death 5 to 5	Ectopic pregnanc Other (specify)	sy		23d. Date o		ry Day Year
Division of Vital Records, P.O. Box	w requires that the deal sbeen signed by the at 2 should be detached for the should be detached for th	by	Part II. Other significant conditions contributing to deat	h but not resulting in the o	underlying cause giv	ven in Part I.				e cause of death?
ords	been should	letec			-		24a, Was an	24b. Wer	re autop	sy findings available
Š	sician: The law r certificate has b lirector, page 2 sk	Completed					autopsy performe	ed? dea	r to con th?] Yes :	pletion of cause of
		Be	25. Was case referred to medical examiner?		26. Pl	ace of Death (Check				
<u> </u>	Physic r this co	<u>3:</u> 10	1 ☐ Yes 2 1 NO 1 ☐ Ing 27. Manner Death 28a. Date of		nt 3 🗆 DQA	4 LI Nursing Ho	me 5 Residen		Specify)	
u O	inding Phy ath. r: After thi ne funeral o	icate	2 Accident Investigation	Day, Year) injury	work					
INISI	ours after deat eral Director: filled in by the	Certificate:		Injury - At home, farm, str etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,		r Rural I	Route Number,
<u> </u>	within 24 hospital or Attending Physician: within 24 hours after death To the Funeral Director, After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best 2 Medical Examiner: On the basis	of examination and/or inves	stigation, in my opinio	on, death occurred at	the time, date and	place, and due to	the cau	se(s) and manner stated.
	To the comple	Σ	only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifier	the best of thy knowledge,	29c. License	e number	290	d. Date signed (A		
D	5		I Motel Leav	und, us	2 (06689	6	7119	110)
	0,0		30. Name and address of person who completed cause of Matthew M. Leonard, MD	8600 Old	Georgetow	n Road, I	Bethesda,	MD 208	14	
	Sta Registr			strar's Signature	wed					_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death July 15, 2010 Year 5:20 pm Albert Kien Dan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 🗆 Months Days (Month, Day, Year) 01/29/1929 China 81 131-24-2572 Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🗓 No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20904 U.S.A. 601 Warrenton Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Specify Asian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Restaurant Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zhu Yulang Chan Chuan En Zheng 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18607 Reliant Drive. Gaithersburg. MD 20879 Alvin K. Dan - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 07/22/2010 Silver Spring, MD 4 Denation 5 Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Sonature of Funeral Service Licenses MUTO7 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear, failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Metastatic Gastric Cancer disease or condition resulting in death) Due to (or as a consequence of): Non ST Elevation Myocardial Infarction Due to (or as a consequence of): Aspiration Pneumonia Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Pregnant at time of death

Physician/ Medical Examiner Examiner

attending physician and for use as the burial-transit

been signed by the a

has ' page 2

funeral director,

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

12

Hospital

To the

Physician/Medical

Completed by

Be

2

Certificate:

Medical

IF FEMALE:

27. Manner of Death

1 X Natural

Accident

3 Suicide 4 Homicide

29a. Certifier

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Examiner

Funeral

Director

fshow

"natural", or items 23a or 28a-f sho dical Examiner must be notified at

th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I

and 2 s Health a

Jermit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once.

Funeral Director

Completed by

Be

be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23e. Did tobacco use contribute to the cause of death?

Anemia

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24a. Was an autops\ performed? Yes 2 X N 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Diabetes Mellitus - Type 2 25. Was case referred to medical examiner? 2 X No 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA

Investigation

determined

5 Pending

28a. Date of injury (Month, Day, Year) 28b. Time of injury 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 2 No

Other:

28f. Location (Street and Number or Rural Route Number,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

29c. License number NO068681

July 19, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, Maryland 20910 Charu Maheshwary, MD. 31. Date filed (Month, Day, Year)

🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 20 2010 **Physician** 2200 July William Franklin Durnbaugh, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/19/1936 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1√ M 2□ F 74 Washington, D.C. 218-30-8319 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 4.2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 is marked other than "natural", or flems 23a or 28a-f show fraumatic event, fire fired from its neither neithed. 1 □Yes 2 👿 No Director Broomes Island Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20615 9010 Broomes Island Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√√√No Specify: Specify: þ White 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Electriction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Gray William Franklin Durnbaugh, Sr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 176 Broomes Island, Maryland 20615 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar Lori McCarty / Daughter-In-Law permit. Pages 1 and :
Department of Health
Important: If item 27
any injury or other tra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Southern Memorial Gardens 07/23/2010 Dunkirk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4405 Broomes Island Road, Port Republic, Maryland 20676 M01206 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 5 ☐ Other (specify) signed by the a d be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Inpatient 2MER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, Hospital or Attending thin 24 hours after death, the Funeral Director: A suppletely filled in by the fu

Maryland 21215-0036

Baltimore,

Box 68760.

Ö

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Jonathan

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

110 Hospital Road Suite 310 Prince Frederick, MO Lowenthal, MD

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

32. Registrar's Signature 31. Date filed (Month, Day, JUL 21 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ J_{uly}^{∞} 22, 6:15 AM Norley Louise Ellis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House Prince George's Laurel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2🗶 F Mar 26, Months Days Hours Min. New York Director 87 1923 094-18-2888 Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20724 3394 Old Line Avenue hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14 Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Il Hygiene. Specify: White Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev John Maedl Nora Lee Schultz 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3394 Old Line Avenue Laurel, MD 20724 Norley L. Kling/daughter/POA Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Final Journey Crematory 07/24/10 1 Burial 2 XCremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Livens Colingan Holles Cremation Service P.O.Box 784 Clarksville, MD 21029 MO1251 Beverly L. Heckrotte, P.A. 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Alzheimer's Dementia Physician disease or condition vears Medical resulting in death) Due to (or as a consequence of) Examiner Seizure Disorder 3 years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buna Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been signated to page 2 should to Completed Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of 24a, Was an Diabetes Mellitus autopsy perform death? 1 Yes 2 No Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No 1X Natural 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) ATTENDING D57216 July 22, 2010 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Michael Baako, M.D. 3450 Fort Meade Rd. #209 Laurel, MD 20724 31. Date filed (Month, Day, Year) JUL 23 2010 State

Registrar

Please Type or Print in Black Indelible Ink Fasure All Gopies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George David Eccard, Sr. 2010 July 19 5:20 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clin<u>ton</u> Southern Maryland Hospital Prince George If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Jan. 12 . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months 212-30-4758 82 **Director** 1928 Jan. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Charles 1 Yes 2 No LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7045 Gorham Lane 20646 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Eraminations. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ò 1 Never Married 2 X Married 1 Ves 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Tes 2 No Specify: 1946-3 Widowed 4 Divorced Completed Year or Dates a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mechanic U.S. Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David C. Eccard Olive Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie A. Eccard Wife 7045 Gorham Lane, LaPlata, Md. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) [©]July 2 Gardens 24, 2010 Trinity Memorial Waldorf. Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. Signature of Funeral Service Lice M00668 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20640 23a. Part 1. Enter the disease, or complications that caused shock, or bean failure. List only one cause a each line Approximate Interval Betw ANTENIO Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securitally list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Yea 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying signed b 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy within 24 hours after death.

To the Funeral Director: After this certificate ! 1 ☐ Yes 2 ☐ No Physician: of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: မှ 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending work? 1 \(\subseteq \text{Yes} \quad 2 \(\subseteq \text{No} \) **Natural** iniury 5 Pending Division ☐ Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 15+1 completed cause of death (Item 23a) (Type, Print) D LINE CENTER State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) July 19 2010 Physician/ Lynsay Margaret Flurry 03:29 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year Feb 2. 1963 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Months Days 1 □ M 2**X**X Hours 578 94 4708 Director Washington DC Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director 1 ☐ Yes 2XX No Anne Arundel Lothian Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20711 United States 87 Edwards Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2XX No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 21√27No Specify: White 3 Widowed 4 X Divorced or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bank Teller Banking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) June Carol Dewing Robert Albert Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) June Carol Gardner (Mother) 12804 Jackson Drive, Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 🛣 Cremation 3 □ Removal from State 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot Clinton, Maryland Lee Crematory July 24, 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria of Funeral Cen m00257 Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEPATITIS AL COHOLIC Physician ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No After this certificate 1 Yes 2 L or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064985 7/19/10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory Chike Onwuka M.D. 7503 Surratts Road, Clinton, MD 20735 32. Registrar's Signature 31. Date filed (Month, Da

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2613 JUL 2000 Michael Lynn FEIGLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 18635 Carolyn Street Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Months 1**X** M 2□ F Yrs. 217-74-6646 5 1958 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "wedical Experience must be netified at 1 ☐ Yes 21 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 18635 Carolyn Street 21742 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ White 3 Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event, Item 1. Elementary/Secondary (0-12) College (1-4or 5+) hodge Brick Mason 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Willing Burwell Clarence Henry Feigley, Jr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 55 Randolph Avenue, Hagerstown, Md. 21740 Clarence H. Feigley, Jr.-Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/27/10 Hagerstown, Maryland Hagerstown Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4/1 **Physician** Colur Metestebr disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the burial pe Physician/Medical Hospital or Attending Physician; The law requires that the death certificate IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) □Yes 2□No Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

JH-1

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month

Corneck 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

medial Compro thejestom MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 17/10 7:19 P M Physician/ Gray Jr Vincent Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George Clinton Southern Maryland Hospital 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Days Min 1 **X**M 2 □ F 53 Marvland **Director** 220-66-8269 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director ty⊡ Yes 2 □ No Maryland Prince George Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20613 13624 Tower Rd 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes If Yes, Give þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Trucking Driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen E. Butler Vincent C. Gray Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tower Rd, Brandywine Maryland 20613 Helen E. Gray/ Mother 3624 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/26/10 Clinton Maryland Senatur of Funeral Service Lifensee 22. Name and Address of Facility Adams Fuberal Home Pa, Aquasco MD 20608 M01589 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE ATHEROSCLEROTIC CARDIOVASCULAR Physician/ disease or condition Medical resulting in death) DIESEA Due to (or as a consequence of) Examiner FIDRILATION VENTRICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown HYPERTENSIUN Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? To the Funeral Director: After this certificate completed filled in by the funeral director, page 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ P/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d Describe how injury occurred Natural Accident 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL K. MAHAJAN. MD.

32. Registrar's Signature

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31. Date filed (Month

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7503 SURRATTES RUAD CLINTUN MD

SUATHERN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:00P 16, 2010 Ju₁y Aloysius Gannon, Jr. Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles 2104 Briarwood Drive Waldorf Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year May 12, 19 If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) Sex 1 M 2 □ F **Funeral** Months Days Hours Min 1934 577-48-9315 76 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Charles Waldorf 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20601 USA 2104 Briarwood Drive "natural", or items 23a Funeral within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗓 No
If Yes, Give 1 Never Married 2 Married Specify: White Baltimore. Maryland 21215-0036 1 □Yes 2X No Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Metropolitan 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas A. Gannon, Sr. Louise Fitzpatrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print, 2104 Briarwood Dr. Waldorf, MD 20601 Susan Rogers Gannon, Wife permit. Pages 1 al Department of Hea Important: If Item any injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify ntombment 7/21/2010 Gate of Heaven Silver Spring,MD 21. Signature of Funeral Service Licensee ²²AREHART-ECHOLS FUNERAL HOME, P.A. a 211 St. Mary's Ave. La Plata,MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and defacted for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part Ii, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Inknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2 No 2 🗆 No 1 □Yes Hospital or Attending Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 Yes 2 Vio 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 Homicide 24 hours a th-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P P.O. Box 1703, La Plata, MD 20646 31. Date filed (Month, Day, Year)

JUL 20 2010 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 5:27 PM William Grimm. Jr 32 2010 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Health Cape Center Washington County Hagerstown # Under 1 Year | ff Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 24, 1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours 1**X**1M 2□ F Pennsylvania 213-40-4371 Usual Residence of Decedent 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2X No Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 17721 Gardenspot Dr. 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Forces.

1 XYes 2 No.
If Yes, Give 1964 - Year or Dates 1968 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) Correctional Dietary Officer State Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William C. Grimm Ruth Keefe Grimm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 Lockett Ridge Rd. Midlothian, VA 23113 Anne Newkirk-sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 7-24-2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Lice Kartlein Saffaron: Jutes 1331 Eastern Blvd. North Hag

23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd. North Hagerstown, MD 21742 Immediate Cause (Final disease or condition resulting in death) a. Aspiration P
Due to (or as a consequence of): Preumonia malionant Ascites Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Rectal Carcinoma with Metastosis malianant that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DDA

Physician /Medical Examiner The law requires that the death certificate be executed ng physician and as the burial-transit Division of Vital Records, P.O. Box 68760, attending for use as signed by the a

Exam

Completed by Physician/Medical

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Certification:

Medicai

Physician

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Examiner

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Maryland

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Pages 1 and 2 should be filed within 72 hours atter death with nent of Health and Mental Hygiene. And the file and Mental Hygiene. The marked other than "naturel; or Itame 23e or Itame 17 is marked other than "naturel; or Itame 23e or Itame Itame

Department of H Important: if Ite eny injury or ot once.

altimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1XNatural

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

28c. Injury at Work? 28b. Time of Injury

28d. Describe how injury occurred

3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

2 Accident

29a. Certifier

29c. License number R125360

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 7/22/2010

er CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbura A. Waren-Blucker, CRNP 333 Mill Street, Huberstown, MD 21740

SHIDHI State

or Attending Physicien:

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s after death.
I Director: After this of in by the funeral d

within 24 hours aft To the Funerel Di completely filled in To the Hospitel

2010

32. Registrar's Signature news A. park

DHMH 17 Rev 1/2001

Registrar

		For State Registrar		State of Ma	aryland.		rtment of H tificate of L		Ment		ene g. No. 2	010	21.53	n
		1. Decedent's Name	(First, Middle, La	ast)						ite of Death			3. Time of Death	Ų_
Physicia /Medic				oris Elli	s Gos	sett				onth July		2010	11:40pm	_
Examine	er		-	ve street and number)	1		4b. City, Town, or					unty of Death		
		Kenaussan 5. Social Security Nur		ens - Ride	TWOOA e (In yrs. last	hirthday	If Under 1 Year	er Sprin		ate of Birth			George's	n
Funeral Director		288-36-53	47	1 M 2 M F	70	Yrs.	Months Days	Hours Min.	12	ate of Birth fonth, Day, /27/19	Year) 939	Col	nplace (State or Foreign untry) Ohio	
and **		Usual Residence of D	Decedent 10b. County		10c. City, T	own or Loc	ation						10d. Inside City Limits	_
f sho	ō	Maryland	Driva	e George's			ç,	lver Sp	hiva				1 ☐ Yes 2 💆 No	
the N	Director	10e. Street and Numb		e deorige s			10f. Zip Code	LVEL Sp	rung	10	g. Citizer	n of What Co	untry?	_
3a or	٥			Road, Apt.	406			20904				u.s	.A.	
ms 2	Funeral	11. Marital Status	-Cyrecou	12. Was Decedent		13. V	Vas Decedent of Hi Yes, specify Cuba		Specify Y	es or No-	14.	Race - Ame	rican Indian,	
Ø 0 €	by Fu	1 ☐ Never Married		Armed Forces? 1 □Yes 2 ☑ If Yes, Give Year or Dates:	No		Yes, specify Cuba	Specify:	to nican	, etc.)	Sį	Black, White pecify:	white	
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hin 7.	ple	(Specification)	y only highest gr dary (0-12)	rade completed) College (1-4or 5	i+)		kind of work done of OO NOT use retired			1			vrtment	
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2 should be filed within and Mental Hygiene. Is marked other than "raumatic event, the Mental and the Men	Be (17. Father's Name (F						18. Mother's Na						
Men Men arke	မ			<u>onard Elli</u>								wilso		_
2 sh h and r Is m		19a. Informant's Nan	•		1		g Address (Street a							
1 and Health em 27 ther tr		Hermeena K 20a. Method of Dispo		ll/Persone					Date Date			tion - City or		_
Pages nent of I ant: If ite ary or o		1 🔀 Burial 2 🗆	Cremation 3	Removal from State			sition (Name of natory or other plac	i i				•		
		4 □ Donation 5		nsop Ma # lor			em. Park					y, Mar	ykana L Home, Inc	
Departit. Departit Imports any Inji		Norman Norman	A A	HO # 10	10 F								ing, MD 209	
		23a. Part 1. Enter Lo	ase, or con	nplications that caused y one cause on each li	the death.							,	Approximate Interval Between	
Physician		Immediate Cause (F	inal									_	Onset and Death	
/Medical		disease or condition resulting in death)	-	a. Corona Due to (or as			aseuse							_
Examiner				, End St	age Re	nal I	isease							
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ecute and trans	Examiner	if any, leading to imm cause. Enter Underli Cause (Disease or in that initiated events resulting in death) La	íjurý				ive Pulmo	nary Dis	ease	2				
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icate be executed physician and s the burial-transit	edical		•	d										
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tt the de by the tached	ıysi	9 ☐ Unknown	INO	9 ☐ Unknown										_
res that signed to be deta	by PI	Part II. Other signific	cant conditions	contributing to death b	ut not resultir	ng in the ur	nderlying cause give	en in Part I.	2	23e. Did tob	acco use	contribute to	the cause of death?	
w require been sig should by		Congest	tive Hea	<u>rt Disease</u>						1 🗌 Ye	s 2 🗍	No 3□ Pi	robably 4 🗶 Unknow	n
law re as ber 2 sho	Completed								. 2	24a. Was an		24b. Were au	topsy findings available completion of cause of	е
The la	mo.									perform		death?	2 No	
siclan; Th certificate rector, pag	BeC	25. Was case referre	ed to medical					26. Place of De						
hysic his ce I direc	일	1 Yes 2 X N	No.	Hospital: 1 ☐ Inpation	ent 2 EF	R/Outpatier	nt 3 □ DOA Oth	er: 4 🗓 Nursing	Home	5 🗌 Reside	nce 6[Other (Spe	cify)	
ding Pt h. After tr funeral	.: O	27. Manner of Death 1 X Natural	5 Pending	28a. Date of Inju (Month, Da	ıry 28 ıy, Yea <i>r</i>)	3b. Time of Injury	Work		28d. [Describe how	w injury o	occurred		
tendi leath. tor: / the fu	cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not	he				Yes 2□No	201			A11	Courte Alicentes	_
or Attending Physician: The law requires that the death certificate death. Director: After this certificate has been signed by the aftending in by the funeral director, page 2 should be detached for use as	Certification:	4 ☐ Homicide	determine	286. Place of int	ury - At nome c. <i>(Specify)</i>	e, tarm, str	eet, factory, office			city or Town		Number or H	ural Route Number,	
spital ours neral filled		29a. Certifier	1 🗘 Certifying F	Physician: To the best	of my knowle	edge, deat	h occurred at the tir	me, date and place	ce, and d	lue to the ca	ause(s) a	ınd manner a	s stated.	_
To the Hospital or Attendin y within 24 hours after death. To the Funeral Director: Afcompletely filled in by the fur	Medical	(Check only 2 one)	2☐ Medical Exa	aminer: On the basis of and manner st	of examinatio	n and/or in	vestigation, in my o	pinion, death occ	curred at	the time, da	ate and p	lace, and due	e to the cause(s)	
To the Vithing Comp.	ž	29b. Signature and ti	itle of certifier	7) 11			29c. Licens	e number		29	d. Date	signed (Mont	h, Day, Year)	
12		La	elen	lithum	ang	MI		D59524			Ju	ily 20	, 2010	
'		30. Name and addre	ss of person who	o completed cause of o										
		Loveen J.		ana, 3110	Graces	ield	Road, Si	lver Spr	ing,	Mary	llanc	1 20904	7	_
Stat Registra		31. Date filed (Month	2 2 20	10 Denve	ar's Signatur	for	Ked							

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Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month

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		-	For State of Ma State Registrar	ryland	•	tificate of D				Reg. No.	2010	24532		
	Physicia		1, Decedent's Name (First, Middle, Last) Sally Elizabeth Gruys					2	2. Date of Dea Month July	Day 29 ,	2010	3. Time of Death 6:35 P ^M		
	Medic Examin		4a. Facility Name (if not institution, give street and number) Sunrise Assisted Living of Freder	rick		4b. City, Town, or			\neg	unty of Death Frederi				
	Funeral Director			(In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	24 Hrs. 8	B. Date of Birt (Month, Day					
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. City, To	own or Loc	ation Freder	ick	-1				0d. Inside City Limits 1 X Yes 2 \(\text{No} \)		
	with the M 23a or 28 ist be noti	Funeral Director	10e. Street and Number 990 Waterford Drive			10f. Zip Code 21	702		1	-	of What Coun	rtry? f America		
920	ould be filed within 72 hours after death with the Maryland and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f sho marked other than "natural", or items 23a or 28a-f sho marke other, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Event Armed Forces? 1 Yes 2 Nover Married 15 Yes, Give		If	Vas Decedent of His Yes, specify Cubar	n, Mexican	i, Puerto Rio	y Yes or No- can, etc.)		Race - Americ Black, White, ecify: Whi	etc.		
Maryland 21215-0036	thin 72 hour sne. than "natur ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+		(Give k life. DC	ent's Usual Occupa kind of work done di O NOT use retired) Onemaker	ation uring most	t of working			of Business Inc	dustry		
73	be filed wit ental Hygie rked other ic event, th	To Be (17. Father's Name (First, Middle, Last) Alphus McCullen Gwaltney			ollellaker.			First, Middle, anderson	Maiden Surr	wn Home			
, Mary	trau	П	19a. Informant's Name/Relationship (Type, Print) Martha Eilene Gruys / Daughter			g Address (Street a								
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cem	etery, crem	sition (Name of natory or other place set Gardens	e) {	Da 8/05/2			ion - City or To 7 , Utah	wn, State		
Balt	21. Signature of Fureral Service linensee M01433 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland										vland 21	701		
}	Medical Examiner sthe private percentage by the private transit sthe private transit states the privat	al Examiner	23a. Part 1. Enter the disease, or complications that caused in shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imply that initiated events resulting in death) Last Due to (or as a Due to	monia consequend consequend	ce of): ce of):	r the mode of dying	, such as	cardiac or r	espiratory an	est,	:	Approximate Interval Between Onset and Death Week		
89	ath certif attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown d	☐ Fetal del	eath 3	Ectopic pregnance	у			23d	l. Date of delive	ery Day Year		
Js, P.C	requires that the death been signed by the atte should be detached for i		Part II. Other significant conditions contributing to death bu Alzhelmer¹s Type Dementia	t not resultii	ng in the u	nderlying cause giv	en in Part I	l. 				ne cause of death?		
Division of Vital Records,	cate has bee	Completed by							24a. Was autor perfo 1 \(\sum \) Yes	osy ormed?		psy findings available mpletion of cause of 2 No		
Vital	lysician Is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatien	nt 2 🗆 ER	l/Outpatien	Othe		th <i>(Check o</i> ursing Hom		dence 6X	Other (Specify	ssisted Living		
on of	to the hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s	Certificate:	27. Manner of Death 1 ↑ Natural	/ 28	b. Time of injury	28c. Injury work	at	28	d. Describe h	now injury oc	curred			
Divisi	urs after durs after draid Directe		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	(Specify)				ļ	City or Tow	n, State)		Route Number,		
1	the nask hin 24 ho the Fune npleted fi	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of m 4 dical Examiner: On the basis of exa Certifying Nurse Practioner: To the b	amination an	nd/or invest	igation, in my opinio leath occurred at the	n, death oc time, date	ccurred at th	ne time, date a and due to th	and place, an e cause(s) an	d due to the ca d manner as st	use(s) and manner stated. ated.		
	o d wit		29b. Signature and title of certifier Palle	2e C1	RUI	29c. License	number) 866	37			igned (Month, 201			
			30. Name and address of person who completed cause of de- Ellen R. Farrell, CRNP 3250 S	tarting	g Gate		dbine,	Maryl	and 2179	97				
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar AUG 0 5 2010	's Signature	A .	boules								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Regina Hall Mary 3:20 PM M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex **Funeral** (Month, Day, Year) Jan 5. I Days Hours Harned 401 32 8277 82 Director Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10a. State Director 1 🗆 Yes 2 📈 Prince George's Clinton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20735 United States 9513 Pryde Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3XXWidowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Clerk Heck Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Conkwright Nora Fitzhugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14628 24th Ave E. Tacoma, Washington 98445 Edwin H. Hall, Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory July 23. 2010 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d mars lexandria Ferry Road, Clinton, MD 20735 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? signed by the atte Month 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ûnknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 2 No Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 욘 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 6 Cou not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide det mined Medical an: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physic 2 Medical Examina 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check actioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [Certifying Nurse F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

222

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State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per me, g907 09/01/2010 the Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:35A M Hindle Ju₁y 16, 2010 Mamie Elizabeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles La Plata Charles County Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2X F Yrs. 225-40-8366 81 May 11,1929 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Director Charles MD La Plata 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10833 Charles Street 20646 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XX No White Specify. Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harris Lewis Lorena Lewis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10811 Charles Street, La Plata, MD Brenda Spooner/Daughter 20646 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery 7/20/2010 La Plata, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22. AREHART-ECHOLS FUNERAL HOME, P.A. du St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Duello (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law ertificate has rector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1

✓ Yes Be 26. Place of Death (Check only one) this a Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Jr A. Je after dea. Je Director: A Je by the 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide A 24 hou... the Funeral Director 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier July 19, 2010 Kanika Hampton, M.D. vho completed cause 32. Registrar's State 20 2010 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ \mathbf{A}^M 2010 8:30 Elsie July 16 Camera Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3915 Sugarloaf Drive Frederick Monrovia Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🏻 F Months Days Hours (Month, Day, Year) av 25, 1922 Massachusetts 88 Director 016-16-6728 Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the M. di. al Examiner must be notified at Director 1 Yes 2 No Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21770 United States 3915 Sugarloaf Drive or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: "natural", If Yes, Give Specify: 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecelia Silva Manual Camara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 3917 Sugarloaf Drive Monrovia, Maryland 21770 Michael Heron / Son Date 21. 20c. Location - City or Town, State New Bedford, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July ∠i 20<u>10</u> ĕ 1 Burial 2 Cremation 3 Removal from State injuny St. 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery Massachusetts 21. Sign/ture of F 22. Name and Address of Facility Stauffer Funeral Homes, P.A any E. Ridgeville Blvd. Mt. Airy, Maryland 21771 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition nysician/ Medical resulting in death) Due to (or as a consistence of): Examiner MUN Sequentially list conditions, it any hading to in mediate cause. Enter Underlying Examine Due to for an a consequence of: attending physician and for use as the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown P.O. þ Part II. **Other signifi⊏ant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed i Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Thinknown U10 Sepsi 24b. Were autopsy findings available 24a Was an Hospital or Attending Physician; The law page 2 s prior to completion of cause of death? certificate has performe 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KNo 1 🗌 Yes ပု 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 only one Gertifying Nurse Practioner: To the best of my knowledge, deeth consend at the time, date and place, and due to the cause(s) and manner as easier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Gail Griffin,

31. Date filed (Month, Day, Year)

MD 55/04

1502 S. Main Street Mt. Airy, Maryland 21771

16/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ Emma G. 2010 Jackson July 1630 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5806 Rosebay Court <u>Frederick</u> Frederick 8. Date of Birth
(Month, Day, Ye Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 💢 F Mary land Director 63 214-46-7365 1947 Usual Residence of Decedent show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland innert of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State Director 1 Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5806 Rosebay Ct. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: black 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>electronic assembler</u> manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ LeRoy W. Cromwell Emma M. Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5704 Charstone Ct., Frederick, Brian Jackson/ son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 7/24/2010 Smithsburg, MD 22. Name and Address of Facility Keeney & Basford Funeral Home . Signature of Funeral Service Licensee apuly 1au MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Atheroscleratic corona Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a conseguence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Paroxy sonal atrial Ebrillation Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month ☐ Pregnant ☐ Unknown Pregnant at time of death 5 Other (specify) signed by the 1 ☐ Yes ∠ 9 ☐ Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital: 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death. Funeral Director; A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

		For State	Plea	se Type or F State of		id / Dep		lealth ar	re All Copie nd Mental Hy	/giene	201	n 21.52
Physicia Medic		Registrar 1. Decedent's Name John	e (First, Middle,	Last) Jameson	, Jr.		imoute or i	Joann	2. Date of De Month July	Reg. No eath Da 16		3. Time of Death 5:05 P M
Examin Funeral Director		4a. Facility Name (if Montgome 5. Social Security No. 578–22–0	not institution, ery General umber 1849	give street and number	er)	ast <i>birthday)</i> Yrs.	4b. City, Town, o Olne If Under 1 Year Months Days	y If Under 24		M.	County of Dea Sontgome 9. Bi Co 26 Ma	
Maryland 28a-f show lotified at	irector	Usual Residence of 10a. State Maryland	10b. County	ard		y, Town or Lo	ne					10d. Inside City Limits 1 ☐ Yes 2 ♣️ No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.	d by Funeral Director	10e. Street and Nun 3204 Ha 11. Marital Status 1 □ Never Marr 3 🏝 Widowed	nyloft (12. Was Decede Armed Force	es? No				n? (Specify Yes or No Puerto Rican, etc.)	τ	Inited S 14. Race - Am- Black, Whi Specify: Wh	States erican Indian, te, etc.
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f and 2 shou f Health and item 27 is m other traum		20a. Method of Disp	a Jame	son / Daug	20b. F	3204	Hayloft osition (Name of	Court	or Rural Route Numb Woodbir Date	ne, M		1 21797 or Town, State
permit. Page 'Department o Important: If any injury or once.		1 Burial 2 4 Donation 21. Signature of Fur		3 Removal from St pecify Entombmo	ent Cr	est La		Gar.	July 23, 2010 Stauffer F	uner		es, P.A.
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ath certificate be executed attending physician and for use as the bunal-transit	dical Examiner	if any, leading to in cause, Enter Under Cause (Disease or that initiated events resulting in death) i	rlying linjury s	c. COPD	as a consequ	·						Years
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outco 1 ☐ Live Bir 4 ☐ Pregna g ☐ Unknov	th 2 🗌 Feta nt at time of o	aldeath 3	☐ Ectopic pregnan☐ Other (specify) _	су			23d. Date of d	elivery Day Year
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To the Hos within 24 h To the Fun completed	Medical	(Check 2	Medical E	xaminer: On the basis Nurse Practioner: To	of examination the best of my	n and/or inves y knowledge,	death occurred at the 29c. Licens	on, death occu ne time, date ar	urred at the time, date and place, and due to t	and place he cause(29d. Da	e, and due to the (s) and manner a ate signed (Mon	e cause(s) and manner stated s stated.
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DHMH 17 Rev 7/2009

		•	For State Registrar		State of	Marylar		irtment of F <i>tificate of C</i>			Jiene Reg. No. 2	010	24538
	Physicia	n/	1. Decedent's Name (First	t, Middle, Last		nson				2. Date of Dea		20 ° 0	3. Time of Death
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	Funeral	_	Freder 5. Social Security Number	6. Se		HOS: 1t		Frede	If Under 24 Hrs	8. Date of Birth	1	9. Birthp	lace (State or Foreign
	Director		578-48-9552 Usual Residence of Deced	<u> </u>	M 2 □ F	73	Yrs.	Months Days	Hours Min.	Jan. 20	,1937	Wash	ngton, DC
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127 nin	of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	(Specify or Elementary/Seconday		College (1-	4 or 5+)	(Give F life, DO	ind of work done of NOT use retired)		rking			
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y a	d Menta marked natic e	2	19a. Informant's Name/R		s Johns	on	T					rtin Jo	
d2 sho	alth an		Hazel A. J					g Address (Street a Vinding _W					
2 G	Department of Health a Important: If item 27 is any injury or other trainonce.		20a. Method of Dispositio	emation 3 \square		State	cemetery, cren	sition (Name of natory or other plac	i	^{, □} 19,201)	on - City or To	
	Departme Importan any injury once.		4 Donation 5 21. Signature of Funeral S		* 1 0	Met		. Name and Addres					Virginia A.
o 8	. 집 트 등 등		23a. Part 1 Enter the dis	y O fl		M0/393			_			amascus	MD 20872 Approximate
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certifica	anding p		IF FEMALE: 23b. Was decedent pregn	Idill	23c. If yes, out			Ectopic pregnanc	v		23d.	Date of delive	ery
e death	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ns?		ant at time of		Other (specify)	у			Month	Day Year
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he Hos	in 24 ho he Fune	Medical	(Check 2 🗆 M	ledical Exami	ner: On the basi	s of examination	on and/or invest	occured at the time ligation, in my opinion death occurred at the	on, death occurred	at the time, date a	nd place, and	d due to the ca	use(s) and manner stated.
To 1	To t		29b. Signature and title o	f certifier	7. N	10		29c. License	7657			gned (Month, i	
			30. Name and address of				m 23a) (Type, F		1021			(110	
	Stat	te.	Anish Suman 31. Date filed (Month, Day	nt Desa v, Year)	i MD	400 We	st 7th	Street,	Frederic	k, MD 22	204	-	
	Registra			111 21	2010	Lies. W.	is file !	Backer					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ lones Month Vande Medical luly 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 8. Date of Birth Nov. 28, 1911 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 DM 2 X F 98 Mary land 218-09-7814 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits Director Maryland Washington Boonsboro 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21713 6409 Old National Pike U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Preparation Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vinton C. Jones Edith Elizabeth Martz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Cronise / Grandson 6573 Gilardi Road Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/26/2010 Boonsboro Cemetery Boonsboro, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Bast-Stauffer Funeral Home. PA (diea 7606 Old National Pike Boonsboro, MD Part V Enter the disease, or comp vation v that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Verce disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of sician and burial-transit death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) ed by the a detached f Unknown g Unknown P.O. I signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has page 2 autopsy Hospital or Attending Physician: The this certificate 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After Natural 5 ☐ Pending _ Investigation work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide 24 hours after deat Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and miner as attacks.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one) 29b. Signature and title of dertifu 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registr<u>ar</u>

DHMH 17 Rev 7/2009

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32. Registrar's Signature

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JUL

31, Date filed (Month, Day, Year,

		-	For State of Ma	aryland / Dep <i>Ce</i>	artment of F ertificate of D			giene Reg. No.	0 24540
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physicia Medic		Dorothy Joan Jones				July	2 ^{Day} 20	^a 0 10:45a ^M
	Examin		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of [
-/			Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	Havre d	e Grace	8. Date of Birt	Harfor	Birthplace (State or Foreign
	Funeral Director		215-30-3530	76 Yrs.	Months Days	Hours Min.	Jan 8	1934	Country) PA
	ld now	١	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	arylar ia-fst	Director	MD Cecil	Rising S	un				1X Yes 2 □ No
	or 28 e not		10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	t Country?
	s 23a rust b	Funeral	100 McNamee Ln. #306		21911			USA	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ If Yes, Give Year or Dates.	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	n, Mexican, Puerto		Black, V	American Indian, White, etc. White
Maryland 21215-0036	hours natura lical E	Completed	15. Decedent's Education	16a. Dece	edent's Usual Occup	ation	ina	16b. Kind of Busin	ess Industry
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121	d with tygier ther t	امها	2	Lice	nsed Prac			Hospita1 Maiden Surname)	-
anc	be file	To E	17. Father's Name (First, Middle, Last) Edwin Hoster			Dorothy		Waldert Surname)	
ary	nd Me s marl	7	19a. Informant's Name/Relationship (Type, Print)		ling Address (Street a	and Number or Rura	al Route Numbe	r, City or Town, State	e, Zip Code)
ž	d2sh altha n27is		Steven Jones/ Son	277	Cree Terr	ace Risir	ng Sun,	MD 21911	
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 □ XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		position (Name of ematory or other place tingham C	emetery	B/2010	20c. Location - Cit	
Balt	permit. Departr Import any inji		21. Signature of Funeral Service Licensee	يُّ ا	22. Name and Addres R. T. Foar 111 S. Qu	s of Facility d Funeral een St. F	Home, Rising S	P.A. Sun, MD 21	1911
	Ph_sician/ Medical Examiner		23a. Part 1. Entend the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a	the death. Do not en	ter the mode of dyin	g, such as cardiac (or respiratory ar	rest,	Approximate Interval Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	a consection or c_i .					7
09	sate be executed physician and the burial-transit	edical Ex	resulting in death) Last Due to (or as a d	a consequence of):					
Box 6876	certificate anding phouse as the		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome 1 ☐ Live Birth	of pregnancy 2 Fetal death 3	☐ Ectopic pregnand	cv		23d. Date of	
). Bo	the death by the atte ached for	Physician/M	1 Yes 2 No 9 Unknown	t time of death 5	Other (specify)			Month	
ds, P.O.	quires that en signed ruld be det	þ	Part II. Other significant conditions contributing to death be	A Cile	underlying cause gr	ven in Part I.	23e. Did t	: /	rte to the cause of death? ☐ Probably 4 ☐ Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed					1 \(\simeg\) Yes	psy prid	re autopsy findings available or to completion of cause of tth? Yes 2 No
ita	sician certifi rector	Be .	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Vertica vari	Oth	ace of Death (Chec er:			C(f.)
of V	Physer this eral di	ا ا ا	27. Mapper of D th 28a. Date of inju	ry 28b. Time		y at		dence 6 Other (Specify)
ou (ath. r. Afte	icat	1 Natural 5 ☐ Pending (Month, Day	y, Year) injury	M 1 🗆	Yes 2 No	-		
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_	n 24 hours n 24 hours ne Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of the control of the control of the certifying Nurse Practioner: To the	xamination and/or inve	estigation, in my opini	on, death occurred a	at the time, date	and place, and due to	the cause(s) and manner stated.
	To the within comp		29b. Signature and title of certifier		29c. Licens	e number	6	29d. Date signed (M	Month, Day, Year)
	3		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Box 99 C	Mu mao	S CM,	1918	7
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	pares	<i>-</i>			

10-05326 Pamela Jenkins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 24541

		1- For State Registrar		Certific	cate of	Death			Reg. No.			
Physician/ 1. Decedent's Name (First, Middle,Last)						2. Date of Do Month	eath Day	Year		of Death 2 hrs		
Medical Examir			. JENKINS					July 16,	2010	0		2 1115
)		4a. Facility Name (if not instituti 7924 Starwood Court			41	o. City, Town, or L Glen Burnie	ocation of Dea	tn		c. County of Anne Aru		
Funeral Director		5. Social Security Number 148–62–8802		e (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24H Hours M	─			9. Birthplace (S Foreign Country)	
à	ŀ	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Tow	n or Location	n					10d. Ins	ide City Limits
nd show any sce.			E ARUNDEL		BURN							es 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	OF ADE E			10f. Zip Code 21061				izen of Wha	at Country?	
h with the mas 23a be noti	Funeral [7924 STARWOOD 11. Marital Status 1 X Never Married 2	12. Was Decedent		13. Was	Decedent of Hisp s, specify Cuban,	oanic Origin? (Mexican, Puer	Specify Yes or to Rican, etc.)			- American India	n, Black,
fter deat			ivorced If Yes, Give Year or Dates:	X No		Yes 2X No				Specify:	BLACK	
hours a	ted by	15. Decedent's Education (Sp Elementary/Secondary (0-12	ecify only highest grade com	,		s Usual Occupationst of working life.					iness/Industry	
036 rithin 72 ene. ar than '	Completed		4		NURSE					EALTH		
21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle JOHN JENKINS	e, Last)			1	8.Mother's Nar UNKNO	ne (First, Middle WN	e, Maiden	Surname)		
212 ould bo d Ment s mark		19a. Informant's Name/Relation	nship (Type, Print)	ŀ		Address (Street	and Number o	r Rural Route N				e)
MD and 2 sho saith and em 27 is raumati		KENNETH JENKIN	NS/BROTHER			BASIN R		CASTLE,			City or Town, St	ate
nore ages 1 and of Hi		1 Burial 2 X Crematic	on 3 X Removal from Sta	ite	atory or oth	er place) CREMATO	RY 7	/28/201	o I NI	EWARK	, DE	
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ய கடத்த Physician	4	22 m I. Enter the disease, of	or complications that caused	the death. Do		CER-MULI e mode of dying, s					rt Appro	ximate Interval
/Nedical		failure. List only one caus Immediate Cause (Final diseas	se on eachine.			Butalbi					Betwe	een Onset and Death
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	b	equence of):								
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760, ficate be g physici the buri		IF FEMALE:	23c. If yes, outcor	ne of pregnanc	У				23	3d. Date of	_	
certific ending puse as the		23b. Was decedent pregnant in past 12 months?	I Live birti	time of death		aldeath 3 er (Specify)	Ectopic preg	nancy		Month	Day	Year
BOX e death the atte	Physician	1 Yes 2 No 9 V U	9 Olikilowii	durer of the second			B11	Tage Di	d tobacca	usa contri	bute to the caus	e of death?
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Reco The law cate has	gmo								erformed? es 2 l		eath? ✓ Yes	2 No
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F Vid	2	1 ✓ Yes 2 No	Hospital: 1 Inpatie		Outpatient Time of Ir		y at Work?	sing Home 5			Other: Scene	
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Divis	Certification:		ould not be	ouse	, ,			or Tow Apt. I			Starwoo Burnie,	
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying	Physician: To the best of m	y knowledge, o mination and/o	death occurr or investigati	ed at the time, da	te and place, a	and due to the c	ause(s) a	and manner lace, and d	as stated. ue to the cause	(s)
To the conn	Medical	29b. Signature and title of certi	and manner stated.			29c. License					ed (Month, Day	
	٦I	Mousenie	The Shill		-	O.C.1	M.E.		Jul	ly 17, 20	10	
		30. Name and address of person		_		enn Street, Ba	altimore M	D 21201				
	ate	Margarita Korell MD 31. Date filed (Month, Day, Yea		Examiner or's Signature			ammore, IVI					
Regist			2 2010	-	400	Kent						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 20, Day 2010 Year Physician/ July 0745 AM Lamb Marilyn Elizabeth Asplin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent <u>Chester River Hospital Center</u> Chestertown 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XF Months Days Hours Min. Country) 127371927 MN Director 473-28-0571 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☑ Yes 2 ☐ No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 476 Heron Point 21620 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. If Yes, Give Year or Dates Specify:White Completed 3 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Education Professor 6 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rose Marie Feiker Albert Mauritz Asplin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 476 Heron Point, Chestertown, MD 21620 Charles Lamb/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/21/2010 Stevensville, MD Chesapeake Cremation 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home Signature of Funeral Service License 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENEUMONIA Immediate Cause (Final Physician/ AREX disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Inpatient 2 ER/Outpatient 3 DOA Other: 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Descriping Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 0301 29d. Date signed (Month, Day, Year) 29b. Signati

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person

MICHARS

31. Date filed (Month, Day,

STO 5 Cotos Bentoun ms 200%

who completed cause of death (Item 23a) (Type, Print)

(P) MUMUD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene me, g906,08/27/2919dhb Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LABE Physician/ MARY GRACE 12:30 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington County Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign ocial Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖔 F 198-54-8660 Months Days Hours March Day New York 56 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits must be notified at Director Maryland Washington County Hagerstown 1 ☐ Yes 2 🕅 No 10f. Zip Code 23a or 10e. Street and Number 10g. Citizen of What Country? Funeral 12926 Cathedral Ave. 21742 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 ☐ Married is marked other than "natural", or aumatic event, the Medical Examin Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leo Thomas LeBell Lorraine Roe LaBell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) portant: If item 27 is y injury or other tran Karen LaBell-Seidelman-sister 37965 Morrisonville Rd. Lovettsville, VA 20180 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory: 7-27-2010 Smithsburg, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern BLvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events CERTIFICATION APPROVED BY MEDICAL attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed R Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Down Syndrome Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 1 Yes 2 No Yes 2 🖬 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 X Yes 2 □ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 29b. Signature and title of co 29d. Date signed (Month, Day, Year) D0065024 2010

DHMH 17 Rev 7/2009

State

Registrar

5H-3

18101 Prince Phillip Dr., Olney, MD

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

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31. Date filed (Month, Pay Y

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Physicia /Medica Examine Funeral

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Reg. No 2 0 1 0	2454
e of Death	3. Time of Death

•	1 - State Registrar	Certi	ficate of	Death	F	Reg. N2 0	10	24544		
	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	Date of Death Month Day Ye ar				
n i	Angela Denise McCall	lister				15, 201		19:15 P ^M		
r	4a. Facility Name (If not institution, give street and number)	4	b. City, Town, o	Location of Death	1	4c. County	of Death			
	Prince George's Hospital		Cheve	-				eorge's		
		N. Index Direction of the	f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year)	Coui	place (State or Foreign ntry)		
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	Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Locat	ion				1	10d. Inside City Limits		
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ioe.	10e. Street and Number	Upper Ma	10f. Zip Code			10g. Citizen of \	What Cour			
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runeral Directo	Lee W. B. L. E.	IIS 13 Wa		· · · · ·	pecify Yes or No-			can Indian,		
5	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	If Ye	es, specify Cuba	lispanic Origin? (S an, Mexican, Puert	Rican, etc.)	Blac	ck, White,			
2	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 🗆	Yes 2XNo	Specify:		Specify	Afric	can American		
сотріетей ву	15. Decedent's Education	16a. Deceden	nt's Usual Occup	ation		16b. Kind of B	usiness/In	dustry		
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e o	Elementary/Secondary (0-12) College (1-4or 5+)	Audito	r					ansportation		
De C	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Surnan	1e)	_		
0	David Odell Clark			Barba	ara Scot	t				
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town,	State, Zij	o Code)		
	David Clark (Father)	258 J	eter Dr	ive, Pino	ckard, A	1 36371				
	20a. Method of Disposition 20b. 1	Place of Dispositi cemetery, cremat	on (Name of tory or other place	ce)	Date	20c. Location	City or To	own, State		
	4 Donation 5 Other (Specify)	Mount Mar	iah Cem	etery Jul	Ly 29,20	10 Newt	on, A	labama		
	21. Signature of Funeral Service Licensee MOISS	J 22. N	lame and Addre	ss of Facility Lee	Funera	1 Home,	Inc 6	633 01d		
	lessica M. (moros	Ale	xandria	Ferry Ro	oad, Cli	nton, M	D 20	0735		
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ũ	resulting in death) Last Due to (or as a conse	equence of):								
Medical	d									
Med	IF FEMALE:									
ian/	23b. Was decedent pregnant in the past 12 pronths? 23c. If yes, outcome of preg	etal death 3 🗆 E	ctopic pregnanc	у			ate of deliventh	very Day Year		
sician	in the past 12 pronths? 1 □ Yes 2 □ No 4 □ Pregnant at time of 9 □ Unknown	if death 5 ∐ C	Other (specify) _							
Ę.	Part II. Other significant conditions contributing to death but not re	esulting in the unde	erlving cause div	en in Part I	23e. Did to	obacco use con	tribute to	the cause of death?		
o	Tark in Other Significant Schildren Contributing to death backets	Journal of the Contract	onymig occord give			Yes 2 □ No		1		
Сотріете										
npie					24a. Was autop	an 24b.	Were auto prior to co death?	opsy findings available ompletion of cause of		
5					1 □ Yes	rmed? 2 D(No	1 ☐ Yes	2 🗆 No		
De	25. Was case referred to medical examiner?		l Ott		th (Check only o	nne)				
9		ER/Outpatient	3 LI DOM		lome 5 Resid			ify)		
0	27. Manner of Death 28a. Date of Injury 1 Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury	28c. Inju Wor		28d. Describe i	how injury occur	rea			
cat	26 Accident investigation 3 Suicide 6 Could not be	home from about		Yes 2 □No	20f Location (Ctuant and Num	har ar Pu	rol Poute Number		
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spe	cify)	, настогу, опісе		City or To	vn, State)	Jer Or Mül	ral Route Number,		
	29a. Certifier 1 A Certifying Physician: To the best of my k	nowledge death o	occurred at the t	ime date and nice	e and due to the	cause(s) and n	nanner as	stated.		
Medical	(Check only one) Check only one Che	nation and/or inves	stigation, in my	opinion, death occi	urred at the time,	date and place	and due	to the cause(s)		
Mec	29b. Signature and fittle of certifier		29c. Licens	se number		29d. Date sigry	d (Month	, Dav, Year)		
	16.6		0	7021	G	2/	0/			

15 Bach

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans

Division of Vital Records, P.O. Box 68760,

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriment must be rediffed at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ July Barbara Ann Miedzinski 9:04 Medical 4a. Fecility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 305 St. Mary's Ave. La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral 1 □ M 2 X F Min. (Month, September Country) Marvland Months Days Hours 218-38-7683 67 **Director** 1942 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 305 St. Mary's Ave. 20646 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1 Marital Status 14 Race - American Indian. Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes Give 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Adrian Garner Rosebelle Angela Inscoe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20646 Sandy Thompson/Daughter Dorchester Ave. Apt. 38 La Plata.MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 M Burial 2 Cremation 3 Removal from State Trinity Memorial Gar. 7/23/2010 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 22 AREHART ECHOLS FUNERAL HOME, P.A. 20646 21. Signature of Funeral Service Licensee û Mary's Ave La Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons-quence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam Tol that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial-Physician/Medical Box 68760 attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month 5 Other (specify) Pregnant at time of death the detached a Unknown g Unknown P.O. by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death. autopsy 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 █ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DQA To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 A Natural
2 Accident
3 Suicide 5 Pending injury 1 🗌 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Pritchett, M.D. 118 La Grange Ave. La Plata, MD

31. Date filed (Month, Day, Year) JUL 2U

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00008370

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16, Day 2010 Physician/ Month Muller 9:30 P. Barbara Wilkening . Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Clinton Bradford Oaks Nursing Home Prince George's Social Security Number 8. Date of Birth (Month, Day, Year) Oct 17,1931 6. Sex Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Hours Min. 1 \square N 370-32-9567 78 Director Michigan Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Uppper Marlboro Maryland Prince George's 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9904 Frank Tippett Road 20772 LISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc 0 1 Never Married 2 X Married Completed by Yes 2 XXNo f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trave1 Travel Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Marie Hoffman မ permit. Page 1 and 2 should be 1 Department of Health and Menta Important. If item 27 is marked any injury or other traumatic ev Freidel Conrad Wilkening 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9904 Frank Tippett Road, Upper Marlboro, MD 20772 Ronald Muller-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Cheltenham Maryland Veteran's Cemetery July 28,2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, MD 20735 Approximate Interval Betwe 3a. Part 1. Enter the disease, or smplication, that caused shock, or heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal uea
Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X**N 2 🗌 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 👿 No 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mo.

20 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day **Physician** Ricky Lee MYERS, Sr. 2011 /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 12420 Rocky Fountain Lane Clear Spring Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 56 May 28, 1954 Maryland Director 220-64-6366 Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No r than "natural", or items 23a or 28a-f si the Medical Examinar must be notified Director Maryland Washington Clear Spring 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 12420 Rocky Fountain Lane 21722 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Company 12 Job superintendent is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be to nent of Health and Mental Shirley Ann Wishard George Washington Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 it or other tra 12420 Rocky Fountain Lane, Clear Spring, Md. 21722 Jeanne L. Myers - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. St. Paul's Cemetery | 7/29/2010 Clear Spring, Md. Tam and Address of Facility 21. Signature of Funeral Service License Minnich Funeral Home UMM 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, physician the burial Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a I ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2. No 3 Probably 4 Unknown 1 Tyes AN Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy perform Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: A
bletely filled in by the fu 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one. within 2 To the I 29d. Date signed (Month, Day, Year)

JH-4

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

JUL 27

and address of person who completed cause of death (Item 23a) (Type, Print)

ASSTIL

Pigistrar's Signature

10-05599 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene John Francis Mencarini 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle.Last) Physician/ Month Day July 26, 2010 1700 hrs Medical Examiner John Francis Mencarini, 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 7403 Village Road # 18 Sykesville Carroll If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** July 27, 1947 Months Days Hours 075-36-2024 62 Director 1 XX 2 F Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a State 10b County 1 Yes 2 No s 23a or 28a-f show e notified at once. 28a-f show Sykesville Mary land Carroll after death with the Maryland 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? USA 21784 7403 Village Road, Apt. 18 uneral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Yes White If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed 4 X Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 hours ted Elementary/Secondary (0-12) College (1-4 or 5+) uit. Pages 1 and 2 should be filed within 72 h arment of Health and Mental Hygiene. arment of Health and Mental Hygiene. ortant: If team 77 is marked other than "n ey or other transmitie event, the Medical E Construction 2 General Contractor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Angela Carmela Perry Francis John Mencarini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 South Waterford Road, Silver Spring, MD 20901 Theresa Ann Mencarini/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place 1 Burial 2 Cremation 3 Removal from State July 29 Metropolitan Crematory 2010 Alexandria, Virginia 4 Donation 5 Other Specify 21. Signa r of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 Cole Mchle 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on wich line. Between Onset and /Medical Death a Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit ca X AMENDED physician the burial -X UNPENDED hysician/Medi PII,27,per ME g908 10/4/10 TT certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Month Day Fetal death detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) death 1 Yes 2 No 9 Unknown 9 Unknown 0.0 畆 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcohol abuse, cardiac arrhythmia with Completed Records, 24a. Was an 24b. Were autopsy findings available has been prior to completion of cause of death? pacemaker autopsy performed 1 🗸 Yes 2 No certificate page ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other Scene After this 1 V Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural 1 Yes 2 No Pending hours after death. the Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical To the within 7 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 2 PEND 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 27, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar

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31. Date filed (Wen

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $07/21^{ay}/2010^{ear}$ 12:50 a M **Physician** Elizabeth McConnell-Crandell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Tracy's Landing 420 Leitch Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 09/14/1940 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F 69 MA Yrs 027-30-1469 Director Usual Residence of Decedent 10d, Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10h. County 10a. State or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Tracy's Landing 1 ☐ Yes 2X No MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20779 420 Leitch Road by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 11 Marital Status 1 ☐ Never Married 2 A Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo If Yes Give 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nn any injury or other traumatic event, the Mental once. College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Marina 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Wood Herbert Dwight McConnell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 420 Leitch Road, Tracy's Landing, MD 20779 Edwin Crandell/Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee Crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/21/2010 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur of Funeral Servi Lee Funeral Home Calvert, P.A. Mounts 8125 Southern Md Blvd., Owings, MD 20736 Lisa M. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cance years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in continuated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) P.0 s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as s autopsy performed? Yes 2 4 No page 1 ☐Yes 2 ☐ No certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours atter upgan...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier wein , NO KW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road #300, Anapolis, MD 21401 15 «Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0020 M 2010 July Presock Sr. Robert L. Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner icomi (4) regional 9. Birthplace (State or Foreign If Under 8. Date of Birth If Under 24 Hrs. **Funeral** (Month, Day, Months Min. Country) Director Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a, State Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 If Yes, Give Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed 1960-196 Year or Dates 16a, Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Montgo mery event, Be 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ္ Page 1 and 2 should I ment of Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kobert Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 22 4 Donation 5 Other (Specify) Wed CIBAIDFOOK 22. Name and Address of Facility 21. Signature of Funeral Service Licer CEA Removal SERV. 180 Sister Chipmank Ln. 22624 MO1080 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burialnding physician use as the burial Physician/Medical Box 68760 nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I ģ 1 Yes 2 No 3 Probably 4 Unknown Records, been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed thin 24 hours after death. the Funeral Director. After this certificate Impleted filled in by the funeral director, pag 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Hospital or Attending Physician: Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

29b. Signat

Day, Year)

JUL 28

egistrar's Signature

who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Beulah Martha POTTORFF Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) 8. Date of Birth 6. Sex **Funeral** (Month, Day, 1 🗆 M 2 🏻 Days Hours Min. 95 Pennsylvania Director 203-10-9269 June Usual Residence of Deceden 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1337 Marshall Street 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: white 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
homemaker 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) her own home permit. Page 1 and 2 should be filed wit.
Department of Health and Mental Hygier
Important: If item 27 is marked other I
any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Carrie Burkholder William Daley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1337 Marshall Street, Hagerstown, Maryland 21740 Wayne C. Cook - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 7/27/10 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final th (or as a consequence of): Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 Ho Pregnant at time of death 1 Yes 2 L 9 Unknown signed by the a d be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed 2 🗆 No 1 Yes Hospital or Attending Physician: 24 hours after death. To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 010 1 Impatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Tyes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 062588 a, no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Antietan 251

1 X Yes 2 □ No

Onset and Death

SH-1 State

Registrar DHMH 17 Rev 7/2009

JUD int 31. Date filed (Month, Day,

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gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day July 2010 Year 19 10:45 PM Shirley Ann Whittington Powell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Annapolis Anne Arundel Medical Center Anne Arundel g. Birthplace (State or Foreign Country)
Wash., D.C. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth Funeral Hours 01-01-1936 **Director** 578-46-3439 74 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4380 Woodview Lane USA 20678 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 N Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: white Completed 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Facility Human Resources Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Theresa Mullen Henderson Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4380 Woodview Lane, Prince Frederick, MD 20678 John D. Powell, spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1

 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Smithville Cemetery | 07-23-2010 | Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Demythinating heurona Phy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown ate has been signed by the atte page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has le completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No ∏ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🐧 No Other: ျ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of cer

22

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) web und four apolis, MD

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:00 A Elizabeth Pruitt 21, Florence 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury Rehabilitation & Nursing Ctr. Salisburu If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🖺 F 08/24/1918 Maryland 212-03-4691 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment in ust be notified at once. 10a. State 10b. County 1 XYes 2 No Director Maryland Wicomico Fruitland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 212 W. Main Street 21.826 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: white <u>م</u> 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) federal government postmaster 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Grover Pusey Anna Marie Brewer ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 212 W. Main St., Fruitland, MD 21826 Larry Allen - spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 7/21/2010 Hanover, MD 21. Signature of Funeral Service Lio HolTowayd Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9 par Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 1 No 1 ☐ Yes **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 PNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) bins, M. D-William Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Rodney Wesley RIPPEON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington
9. Birthplace (State or Foreign 1029 W. Washington Street Hagerstown
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) Year) **Funeral** Months Days Hours Min MARYLAND 62 March 2 1948 Director 212-50-8270 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination colling at 1∭Yes 2□No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 1029 W. Washington Street 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify. Specify: White 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 Is marked other the any injury or other traumatic event, IT all once. Credit Card Processing 12 Card Processing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glenn R. Rippeon Grace Dodd ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland 21742 Susan Stull - Sister 813 Dewey Avenue, Hagerstown, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory 7/23/10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licen 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseduence of). Examiner b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Hours after death.
certificate has been signed by the attending physician and sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No 9 Hunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 □Yes in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

IARALEL SHERIF 11110 | Medical Compus R ARALEISHERIF 31. Date filed (Month, Day, Year) State JUL 26 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 24555 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ P^{M} 2:00 Mary Alyce Regner 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 18105 Old Baltimore Rd. Montgomery <u>Olney</u> Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Social Security Number 6. Sex 7. Age (In vrs. last birthday Funeral Min. 1 🗆 M 2 🖾 F Months Days Hours 82 Yrs. 1928 <u>Pennsylvania</u> 170-22-5551 **Director** May 14. Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 XYes 2 No Palm Coast Flagler FL 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21 Corona Ct. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedo... Armed Forces? 1 ☐ Yes 2 🏝 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎦 No Specify. If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Government Elementary/Seconday (0-12) Contracting Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Llewella Kashner မ Fred Marshall McGranahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18105 Old Baltimore Rd. Olney, MD 20832 Department of Health Important: If item 27 any injury or other the once. <u>Linda Sickel/Daughter</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 🔀 Cremation 3 🗌 Removal from State Brentwood, Maryland 7/23/2010 Ft Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) MO14 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or jneart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myeloid Leukemia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Myelodyspaltic Syndrome Sequentially list conditions, Due to for as a consequence of Examine if any, leading to immedicause. Enter Underlying physician and sthe burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cate has been sig page 2 should b Completed Be

To the Hospital or Attending Physician: The law requires that the death certificate be execut-Division of Vital Records, P.O. Box 68760 certificate eral Director: After this filled in by the funeral di within 24 hours after d

To the Funeral Direct

Completed filled in by

ed b			1 Tes 2 12 No 3 Probably 4 Unknow
Complete			24a. Was an autopsy performed? 1 \(\begin{array}{ll} Yes 2 \] \[\text{No} \] \(Yes 2 \) \[\text{No} \] \(Yes 2 \) \[\text{No} \] \(Yes 2 \) \[\text{No} \]
Be (25. Was case referred to medical	26. Place of Death (Check on	ly one)
10 B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 Other (Specify)
tificate: 1	27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
Certif	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 29b. Signatur and tit of dertifie 29c. License numbe July 16, 2010 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Phillip Dr. # 327 Olney, Maryland 20832

State Registrar

Medical

29a. Certifier

only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24556 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July_ Day 2010 Physician/ 7:23 A Alma Ruth Smith Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Waldorf Compassionate Care 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** August 7, 1935 1 🗆 M 2 🗶 F Days Hours Virginia 230-38-3944 Director Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10c, City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1X Yes 2 □ No Waldorf Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 110 Jefferson Road 20602 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes Give Specify: White "natural". 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Seconday (0-12) 8th. College (1-4 or 5+) Home Maker Housewife Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Hodge Kelly Riggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3924 Old Washington Road, Waldorf, MD. 20602 Lorie Anspach/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marvland Vets' Cem. July 27, 2010 Cheltenham, MD . Signature of Funeral Service icense 22. Name and Address of Facility Huntt Funeral Home Old Washington Rd. Waldorf. MD 20601 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ⊮nysician/ disease or condition Medical resulting in death) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No cate has; 1 Yes After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 2 XWo ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how inju Certificate: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No ☐ Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

29b. Signature and title of certifier

1124 31. Date filed (Month,

and address of person w

29d. Date signed (Mont

	1 State Registrar		Ce	ertificate of	Death		eg. N2010	24557					
ian	1. Decedent's Name (First, Middle, La Mildred Beach S					2. Date of Deat Month July 22	Day Ye	ar 3. Time of Death					
ical	4a. Facility Name (If not institution, giv			4b. City. Town. o	r Location of Death	July 22	4c. County of D	0015 A					
ner	Heron Point	o or occurrent members		Cheste			Kent	odui					
	Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Forei					
	055-16-8600	ILIM ZEPF C)4 Yrs.	Month Days	TIOGIO IVIII.	6/01/19		ew York					
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limit					
to	Maryland Kent		Chestert	own				1 √Yes 2 N					
Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?					
ral	444 Heron Point			21620			USA						
Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, Ihite, etc.					
by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	'	1 □Yes 2 □ No X	Specify:		Specify:	White					
ted	15. Decedent's Ed	ducation		edent's Usual Occup			16b. Kind of Busine						
ple	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	life.	e kind of work done DO NOT use retired	during most of work d)	ing							
Completed	12	8		wyer			Law	<u>.</u>					
Be	17. Father's Name (First, Middle, Last				18. Mother's Name		•						
မှ	Charles Arthur Be		10. 11.		Elsie Ma			7.0.11					
	19a. Informant's Name/Relationship (ling Address (Street			•	te, Zip Code)					
	Wendy Miller Cos 20a. Method of Disposition	slett/ daugr	20b. Place of Disc	osition (Name of	; [010 20c. Location - City	or Town, State					
	1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			ematory or other plac	i	- /20							
	21. Signature of Funeral Service Licer		\ \ \ \ 2	ke Cremat 22. Name and Addre	ss of Facility	·		-					
	1 Kick OC	Weller		Fellows, 1 130 Speer	Helfenbei Rd. Ches	n & Newr tertown.	nam Funera MD 21620	al Home					
	23a. Part 1. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one due on each line. Immediate Cause (Final												
	Immediate Cause (Final disease or condition		onitie					Onset and Death					
	resulting in death)		consequence of):	i		1							
<u></u>	Sequentially list conditions, b. malanmoumass m Clust												
Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		☐ Ectopic pregnanc	:v		23d. Date of						
sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown		Other (specify)			Month	Day Year					
Ę	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	bacco use contribut	te to the cause of death?					
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DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Me state Amend 30 per HD, DOR, 7/28/10, Certificate of Death	ntal Hygien		24558
			1. Decedent's Name (First, Middle, Last)	. Date of Death	ay Year	3. Time of Death
	Physicia /Medic		Lillie Mae Sampson	July 2:	5 2010	
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		c. County of Deatl	1
					Dorche 9. Birth	
	Funeral Director		214-32-1642 1 M 20 F 82 Yrs. Months Days Hours Min.	Dec. 281	927 M	hplace (State or Foreign untry) AYY/ANd
	p ,		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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Y	r 28a-	rect	10e. Street and Number 10f. Zip Code		Citizen of What Co	untry?
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,	tems	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Richard Company)	ify Yes or No- can, etc.)	14. Race - Ame Black, White	
36	a within 72 hours after death with the Marylan piene. r then "neturs!", or items 23s or 28s-f ehow the Medical Examinat must by multied at	Completed by Funeral Director	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify: B	ack
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	be filed value Hygie od other svent, II		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide	en Surname)	
Maryland	uid be Mental irked i	To Be		nce E	: Cami	0er
Aar	d 2 should th and Mer 7 is marke traumstic	·	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural I	4	or Town, State, 2	Zip Code) 21631
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JOE L	Pages ment of ant: if it ury or c		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cometery, crematory or other place) E. New Market Cemetery, 7/3	1/10 E.	NewMa	rket MD
Baltimor	permit. I Departm Importa sny inju		21. Signature of Funeral Service Licensee	tome, P. F	7.	4.11
_	8° E ≥ 9		formula C Starty 510 Washington	STICAM	bridge	Approximate
			23a. Pany Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final	respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Bend Insufficiency Due to (or as a consequence of):			Months
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	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury			Uears
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89		8	IF FEMALE:	- · · -		
Вох	eath certific attending pl	ian/	23b. Was decedent pregnant in the past 12 moeths?		23d. Date of de Month	livery Day Year
o.	The law requires that the death certific: are has been signed by the attending pl page 2 should be detached for use as t	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
S,	es that igned b	by Pi	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?
ord	w require been sig should t			1 🗆 Yes		robably 4 Monknown
Records,	elawi hasbo	Completed		24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
lal		e Co	25. Was case referred to medical 26. Place of Death	(Check only one)	No 1 □ Yes	s 2 No
f Vital	ysic is ce direc	To B	examiner?	e 5 Residence	6 □Other (Spe	ecify)
n of	ding Ph h. After th funeral		1 Natural 5 □ Pending (Month, Day Year) Injury Work?	8d. Describe how in	ijury occurred	
Division	Attending ir death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	8f. Location (Street	and Number or F	Rural Route Number,
Ω̈́	afor A after Direct	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, St.	ate)	
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the control of the basis of examination and/or investigation, in my opinion, death occurred to the control of the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of my knowledge, death occurred at the time, date and place, and the basis of my knowledge, death occurred at the time, date and place, and the basis of my knowledge, death occurred at the time, date and place, and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the basis of examination and/or investigation, in my opinion, death occurred at the time.			
	the H	Medicai	one) and manner stated. 29b. Signature and title of certifier , 29c. License number		Date signed (Mon	
	tiw Too		Afunaioli - Sheehan D.O. MD H684	13 Xu	ly 27,	2010
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer L. Fun Fassett Magee Health Center 303.4	aioli#She Nuir St.	Cambi	ridge 110
	Sta Registi		31. Date filed (Month, Day, Year) JUL 98 2010 32 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 17: 25 PM-4c. County of Death Jah /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Sherman Quen nester Hune's Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 218-48-8558 land July many Q1 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be rectified at 1 XYes 2 □ No **Funeral Director** nester Queen Hnne's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21638 22 Sherman Way 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Maryland 21215-0036 \ 0 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examination 1 Never Married 2 Married 1 ☐Yes 2 No Specify. þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State (Jovernmen 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Essex, MD 21221 Baltimore, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State Cambridge, Maryland 7-28-10 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Henry Funeral Home, RA. 21. Signature of Funeral Service License C. 510 Washington NID 21613 St. Cambridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on with line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner R16/05/10 Sequestally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No page 2 2 No 1 □ Yes Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To Division of After this 28b. Time of Injury 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 📜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel Wilkerson MD 204 Medical Center Road Grasonville MD 21638

32. Registrar's Signature

D0027055

29d. Date signed (Month, Day, Year)

		1	State of Maryland / Department of Health and Certificate of Death	d Menta	al Hygiene Reg. N		24560
_			Registrar 1. Decedent's Name (First, Middle, Last)		te of Death		3. Time of Death
Phys		n	WILLIAM C SMITH, SR	O _M	7 20	2010	15.30 PM
	edica mine	er	4a. Facility Name (If not institution, give street and number) DORCHESTER GENERAL HOSPITAL CAMBRIDGE			County of Dea	STER
Fune	ral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	Hrs. I a Da	ite of Birth	9. Bir	thplace (State or Foreign ountry) ryland
Direct			220-28-2027 1XM 2 F 77 Yrs. Months Days Hours M	Sep	onth, Day, Year)	932 Ma	ryland
pu .		- 1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Aaryla f sho		.	Maryland Dorchester Hurlock				1 □Yes 2K No
the the	3	Lec	10e. Street and Number 10f. Zip Code		10g. Ci	tizen of What C	ountry?
Sa of	1	a D	4715 Taylor Avenue 21643			USA	
deat		Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1952— If Yes, specify Cuban, Mexican, Pu	? (Specify Your uerto Rican,	es or No- etc.)	14. Race - Am Black, Whi	
72 hours after death with the Maryland natural", or items 23a or 28a-f show	1	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1932 ☐ 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☒ Divorced Year or Dates:			Specify: W	hite
thin 72 hours aft le.		ted	16a Decedent's Usual Occupation	working	16b. K	(ind of Business	/Industry
hin 72 e.		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of v life. DO NOT use retired)	working	36	C	
A vit		Sol	Elementary/Secondary (0-12) College (1-4or 5+) Waste Water Engineer	Nama /Fire	Man t, Middle, Maider	ufactur	ing
d be file	even	Be	The first statute (i. 1881) which is a second state of the first state		abeth Co		
y lo nould d Mer narke	natic	၉	Thomas Hamill Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or				Zip Code)
d 2 sl	ran		Susan R. Smith/Daughter 4715 Taylor Avenue,				
i tan i Heal item 2	otne		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. L	ocation - City o	r Town, State
Pages nent o	ر م		1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fast New Market Cemetery 7/2	24/201	LO East	New Ma	rket, MD
politinity is and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show minimate the training of the traini	any inju		21. Signature of Funeral Service Loensee 22. Name and Address of Facility. Zeller Funeral Ho 106 Main Street,	ome, I East	P. O. Bo New Mar	x 207 ket, MI	21631
	c	1	28a, Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as card				Approximate Interval Between
Physici	ian		Immediate Cause (Final sisses or condition STAGE COPD				Onset and Death
/Medi	cal		resulting in death) Due to (or as a consequence of):				
Examir	ner		Sequentially list conditions. b. PNEUMONIA				
pe:	SII	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
xecut	II-tran	Examiner	resulting in death) Last Due to (or as a consequence of):				
The law requires that the death certificate be executed the has been signed by the attending physician and		dical E	d.				
tificat ig phy	as the	ledio					
eath cer attendin	esn L	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Date of o	lelivery Day Year
cords, F.O. BOX of wrequires that the death certification is greatly be attending a second of the attending and atte	Ded 10	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown				
hat th	detact		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco	use contribute	to the cause of death?
UNISION OT VITAL MECOTOS, to Attending Physician: The law requires the death. Director: After this certificate has been signer.	d be	d by		_	1 🗆 Yes	2 □ No 3 □	Probably 4 Unknown
w req	nous	Completed			24a. Was an	24b. Were	autopsy findings available o completion of cause of
VITAL FREC Sician: The law certificate has b	age 2	dmo		_	autopsy performed? 1 ☐ Yes 2 ☑ 1	death	
an:]	tor, p	Be C			eck only one)		
OI VILA Physician:	direc	0			5 Residence		pecify)
ON O	ınera	on:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28c. Injury at Work? 28c. Injury at Work?	1	Describe how inj	ury occurred	
Attending Physician: If death.	the	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, street, factory, office		ocation (Street	and Number or	Rural Route Number,
Spital or Attend	in by	Certification: T	4 Homicide determined building, etc. (Specify)		City or Town, Sta	ite)	
pita purs purs eral	aly filled		29a. Certifier (Check only 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	place, and	due to the cause t the time, date a	(s) and manne and place, and c	as stated. lue to the cause(s)
the H	completely	ledical	one) and manner stated.				onth, Day, Year)
P with D	CO	Σ	29b. Signature and title of certifier, 29c. License number D0067	41t			
				163		1 - 1	, 0
-		l	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abul Foyez Arifuddowala, M.D., 219 South Washington	n St.	, Eastor	n, MD 23	1601
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Re	gistr	ar	JUL & 2 2010 Senera B. Sparke				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1

			For State		State of N	Marylan	d / Depa	artmen <i>tificate</i>	t of He	ealth a	and M	lental Hy			0	24561
			Registrar 1. Decedent's Name	(First Middle	(ast)			incare	, 0, 0,	Catii		2. Date of De	Reg. N	0.		3. Time of Death
	Physicia		Tae Doo	Shin	, 240,							Month July	D	2010 Ye	ar	12:15 A ^M
	Medio Examin				give street and number)		4b. City.	Town, or L	ocation c	I of Death	July		c. County of I	Death	12.15 A
-) LAGIIIII	CI							ville				١,	Montgo	ners	7
	Funeral		Casey Hou 5. Social Security Nu	mber	6. Sex 7. A	Age (In yrs. la	ast birthday)	If Under	1 Year	If Under		8. Date of Bir	th		Birthpl	ace (State or Foreign
	Director		458-39-36	517	1 X] M 2 □ F	80	Yrs.	Months	Days	Hours	Min.	(Month, Da Jan 12	ly, Year)	930 C	Countr hina	y) 1
	D W	١. ا	Usual Residence of	Decedent 10b. County		100 Cit.	y, Town or Lo			_		1.25			1,0	d. Inside City Limits
	-f sh	턍	10a. State				hesda	Callon							"	1 ☐ Yes 2X No
	e Ma r 28a notifi	je	MD 10e. Street and Num	Montg	Offict A	Det	riesua	10f. Zip	Codo				10 0	itizen of Wha	4.0==	
	within 72 hours after death with the Maryland glent grent than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director			Drive #711	l		208					US/		i Çouni	ry:
	ath w	n l	11. Marital Status		12. Was Deceden		3. 13.1			panic Orig	gin? (Spe	cify Yes or No-		14. Race - /	America	ın Indian.
(0	or ite		1 Never Marrie	ed 2 🗆 Marr	ied Armed Forces	? No		f Yes, spec	ify Cuban	, Mexican	, Puerto F			Black, \	Vhite, e	tc.
21215-0036	rs aft rral", Exal	Completed by	3 🛚 Widowed	Divorced	If Yes, Give Year or Dates			I ☐ Yes	2XL No	Specify:				Specify: A	siar	1
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21	hin 7,	E	Elementary/Seco		College (1-4 o	or 5+)	life. D	O NOT use	retired)	J			_	.1		
	d wit lygie ther nt, th	اما	17. Father's Name (F	irot Middle I	4		Banke	r		10 Moths	wo Name	(First, Middle,		nking_		
Maryland	oe filed varial Hyg	일	Hak Joo S		asi,							Hwang	ivialuel	r Gurriaine)		
Ξ	ould nd Me marl		19a. Informant's Na		nip (Type, Print)		10h Mailir	na Address				Route Number	er City o	or Town. State	a. Zip Ce	ode)
M	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Kathy Shi				3811	Danie	els R	un C	t Fa	irfax,	VA	22030	, -, -	,
ře,	1 and of Hear item		20a. Method of Disp				lace of Dispo emetery, cren	sition (Nan	ne of		0	ate	20c.	Location - Cit	y or Tov	vn, State
<u>m</u>	Page nent c ant: If		1 ☐ Burial 2 X 4 ☐ Donation		3 ☐ Removal from Sta pecify)	^{tte} Fiñ	al Jou	rney	Crem	ator	y 07,	/21/10	Woo	odbine	, MI)
Baltimore,	permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injuy or other traumatic even once.		21. Signature of Fun	eral Service	icensée /) //		GĆ	ing a	d Address One	Crem	ătion	n Servi	.ce_	P.O.	Вох	784 MD 21029
ш	<u>⊽</u> ⊽ = # 9		1 Cleu	ey L	Helitte									arksvi	lle,	, MD 21029
			shock, or hear	t failure. List o	complications that caus nly one cause on each l	sed the deatline.	h. Do not ente	er the mode	eof dying,	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death
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09	ate be executed ohysician and the burial-transit	dical Examiner		1	d										\perp	·
687	tifica ng ph	Me	IF FEMALE:													
9 X	eath certificat attending ph for use as th	ian/	23b. Was decedent in the past 12 n		23c. If yes, outcon	h 2 🗌 Feta	al death 3	Ectopic p						23d. Date of Month		ry Day Year
Box	e dea the a	Physician/Me	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 ☐ Pregnan 9 ☐ Unknow		death 5 L	Other (sp	ecity)				-	Month		Day 15a
P.O.	es that the dea signed by the a l be detached f		Part II. Other signifi	cant conditio	ns contributing to death	but not res	ulting in the u	ınderlying (cause give	n in Part	l.	23e. Did	tobacco	use contribu	te to the	e cause of death?
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ord	v require s been si should b	lete	Hypotensi	on								24a. Was		24b. Wer	e autop	sy findings available npletion of cause of
Sec	he law te has age 2 :	Completed by	пуроссию	.011								auto perf 1 \(\sum \) Yes	ormed?	prio dea	th?	npietion of cause of
E F	sician: The la certificate ha irector, page 2	Be C	25. Was case referre	d to medical					26. Plac	ce of Dear	th <i>(Ch</i> eck		2 131	40 <u> </u> L	163	2
Z.	nysici lis cel direc	To E	examiner? 1 Yes 2 🔀	No	Hospital: 1 ☐ Inp	atient 2 🗆	ER/Outpatier	nt 3 🗆 D0	Other	: 4 □ NL	ursing Ho	me 5 🗆 Res	idence	6 Other (S	Specify)	hospice
Division of Vital Records,	ng Pł fter th meral		27. Manner of Death	5 Pendin	28a. Date of in (Month, I	njury Day, Yea <i>r</i>)	28b. Time of injury	2	8c. Injury work?		- 1	28d. Describe	how inju	ury occurred		
ion	tendii leath. or: Ai the fu	ifica	2 Accident	Investig	gation			М		/es 2 □	-					
Vis	or Atl	Certificate:	4 Homicide	determ	incd 28e. Place of I	njury - At ho etc. <i>(Specify</i>		eet, factory	, office			28f. Location (City or To			r Rural i	Route Number,
	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director, there this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal (29a. Certifier 1	X Certifying	Physician: To the best	of my knowl	ledge death	occured at	the time	date and	place and	d due to the c	21180(8)	and manner a	s stated	1
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2	Medical E	xaminer: On the basis o Nurse Practioner: To the	f examination	n and/or inves	tigation, in	my opinion	n, death oc	ccurred at	the time, date	and plac	ce, and due to	the cau	se(s) and manner stated
	To the within 2 To the comple	_	29b. Signature and t	itle of certifier					. License				29d. D	ate signed (N	lonth, E	Day, Year)
			Joel	lyne	KOUNTEHOU	L, M	D	1	637	148			Jul	y 19,	2010)
	5		30. Name and addre	ss of person v	who completed cause o	f death (Item	23a) (Type, F	Print)		1	4.	1101) 1/	.11		o Der
			JOC	elyn	e wy	afer	LOU	600	Mun	CASTE	P Mi	11/4	60c/4	4.118 M	N A	0855
	Stat Registra		31. Date filed (Month	JUL 23	2010 32 Aegis	strar's Signat	D. A	arker	/					•		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24562 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year July 19, Physician/ 12:20 A M Harold A. Santucci Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Walkersville Glade Valley Nursing Center If Under 1 Year If Under 24 Hrs. Social Security Number Sex 1 M 2 D 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Jan. 22, Year 926 Massachusetts 033-14-5994 Director 84 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 21702 2501 Coach House Way 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give T.T Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 ₩ Widowed 4 □ Divorced WW II Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Company Accountant 4+ any injury or other traumatic event, in once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ DeLauretis Vincenza Santucci Giuseppe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2690 Brook Valley Rd./Frederick, Maryland 21701 19a. Informant's Name/Relationship (Type, Print) Santucci / Son Harry 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State July 21, 2010 Frederick, Maryland Mount Olivet Cem. 4 ☐ Donation 5 🛛 Other (Specify) Entombment Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, P.A. 1621 OPossumtown Pike/Frederick, MD 21702 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final CHRONIC OBSTRUCTIVE LUNG Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SEVERE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CONGETTIVE the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No 1 🗌 Yes 2 🗌 No After this certification funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide
Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ledical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

241VA State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

am moz

32. Registrar's Signature

Gris

31. Date filed (Month, Day, Year)

21944

TANGY AUG #204 FREDERICK, Mb 21702

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:45 a. M 26, 2010 Ju1y Judith Ann SHARER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 13914 Spickler Road Clear Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 🛛 F Jan 28 1940 Maryland 70 Director 215-36-6345 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, it e Medical Experies must be notified at 1 ☐ Yes 2 X No Director Clear Spring Maryland Washington 10g. Citizen of What Country? 10e. Street and Number USA 21722 13914 Spickler Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: \$ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Department Store Sales Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) it and 2 should be fill Health and Mental H tem 27 is marked oth Be Raymond Cecil Valentine Iva Rene Shry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13914 Spickler Road, Clear Spring, Md. 21722 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. Kenneth E. Sharer - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 7/29/2010 Hagerstown, Maryland 21. Signatur Li Firm of Service Licens Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 Me 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic breast cancel 10-20 Year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and Due to (or as a consequence of): physician a the burial-Box 68760, Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No 5 Other (specify) P.O. 9 I Unknown þ signed t d be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Secondary to 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7/27/10 W) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yong Tang, MD 1130 Opal Ct, H Hagerstown, MD 21740 Tang, MO JH-4 Yong 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 19 2010 King Solomon. Jr. 9:00a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9000 St. Andrew's Place College Park Prince George's Social Security Number 9. Birthplace (State or Foreign Country) Alabama **Funeral** 6. Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 0870971933 Director 416-36-4230 76 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's College Park 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral 9000 St. Andrew's Place 20740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1951 — 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced 1980 Year or Dates Black injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Supervisor-College (1-4 or 5+) Elementary/Seconday (0-12) Culinary Art Department United States Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) King Solomon Roberta Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Heatth a Important: If item 27 is any injury or other tra 9000 St. Andrew's Place, College Park, MD 20740 Bobbie P. Solomon - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. 09/27/2010 | Arlington, Virginia 21. Signature of Funeral Service Licensee NO #1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. En., 11-e. isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate is completed filled in by the funeral director, page performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗶 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 29d. Date signed (Month, Day, Year) D D23743 July 20. 2010

State Registrar 7525 Greenway Court Drive. Greenbelt, Maryland 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Weltz.

2 2 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Gladys Leora Schmidt 19 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2610 Old Largo Road Pr. George's Upper Marlboro 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 2/6/192 1 □ M 2 💢 F Months Hours Min. Country) 167-20-9294 **Director** 82 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No Upper Marlboro MD Pr. George's 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 20772 2610 Old Largo Road USA ritems death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 X Married marked other than "natural", or] Yes 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Automotive Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Arthur Spence Evelyn Sheats 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Udine Muenzer/Daughter Westfield Dr.Pr. Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State .1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 17/29/10 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Vets Cheltenham, MD 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Raymond-Wood F.H., P.A. 000 PO Box MD 20754 430, Dunkirk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arterioscleroti disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician; The law requires Completed 1 Tes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the lirector, page 2 s autopsv perform death? 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

7 NW

Registrar

31. Date filed (Month. Day.

only one)

30. Name

3 🗆

29b. Signature and title of certifier

son who completed cause of death (Item 23a) (Type, Print)

12070

32. Registra s Signature

7.10

JUL 21

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ter, Waldorf, mD 20602

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number

10-05373 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Antonio Smith State of Maryland / Department of Health and Mental Hygiene 2010 24566 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Antonio Darrelle Smith 1904 hrs Medical Examiner July 18, 2010 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 510 Emory Court Apt 303 Salisbury Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Director Country)MD 26 220-08-7914 1X M 2 5-8-1984 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Wicomico Salisbury within 72 hours after death with the Maryland MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 814 B Manoa Blvd 21801 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, nt of Health and Mental Hygiene.

11: If item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner must be. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 X Never Married 2 Married Yes 2 X No If Yes, Give Year SpecifyBlack 3 Widowed 4 Divorced 1 Yes 2X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) imore, MD 21215-0036
Pages 1 and 2 should be filed within 77
nent of Health and Mental Hygiene. Laborer Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Patricia Smith Victor Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 B Manoa Blvd, Salisbury, MD 21801 Patricia Smith/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place ardens 1 X Burial 2 Cremation 3 Removal from State artment (7-23-2010 Hebron, 4 Donation 5 Other Specify Spring Hill Mem 21 Signature of Funeral Service Licer 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Finneral Home Salishury, MD 2 rithe disease, or gun, lications that caused the death. Do not enter the mile of lying, such as cardiac or respiratory arrest, shock, or hear MD 21801 23a. Part I. Ente Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cau Fi disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed ian/Medical UNPENDED AMENDED ted by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death Physicia 5 Other (Specify) Yes 2 No 9 Unknown Unknown cate has been signed by page 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? 1 🗸 Yes certificate ✓ Yes 2 No 2 No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, p 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject was assaulted FOUND: Natural 1 Yes 2 V No Pending Jul 18, 2010 1904 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 530 Emory Court Apt 303, Salisbury, MD determined (Specify) Multi-Family Apt. 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c, License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. July 19, 2010 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Cay, Y2r) 2 2010 32. Registrar's Signature Jake State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ Walter July 21 Scott 2:00 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Fruitland 417 S. Camden Ave. . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours Maryland 218-20-9347 82 03/2671928 **Director** Usual Residence of Decedent or 28a-f show 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Fruitland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21826 USA 417 S. Camden Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, et "natural", or 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) meat cutter and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Erma Seward Ben scott 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 417 S. Camden Ave., Fruitland, MD 21826 Helen Scott/spouse Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial
Park 7/24/2010 Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Service License PHOTIOWAY TURETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Chronic Obstructive disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) that the death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: for use a 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 GUnknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diaketes Mellitus 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No page Adenocarcinoma 1 Yes 2 No ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: ပ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

1820 Sweet Bay Drive

rand address of person who completed cause of death (Item 23a) (Type, Print)

J.C. Potrovicz

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ $\mathbf{Julv}^{\mathsf{Month}}$ 2010 04:30 PM Ruby E. Scarborough Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil Laurelwood Nursing Center E1kton Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 30,1925 g. Birthplace (State or Foreign Coulday) Lesboro North Carolina 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛛 F Months Days Hours Director 242-40-1197 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗆 Yes 2 🔀 No Ceci1 E1kton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 United States 30 Walter Boulden Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. traumatic event, the Medical Examiner Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: 3 √ Widowed 4 □ Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pearl Reynolds John Q. Rhoades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Lincoln Avenue, Elkton, Maryland Doris A. McCoy / Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If its any injury or ot 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Julyo²⁹, North East United Methodist Cemetery North East, Maryland 21. Signature of Funeral Service Licensu 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23 Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day signed by the a 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 2 1 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe Jackder. SMD

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

126 A, E

SACHIDEN MD

JUL 2 R 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 July 21 Allan Glasgow Thompson 8:05 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shangri-la Assisted Living Ellicott City Howard Social Security Number f Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y Hours Min 1 XM 2 🗆 F Montana Director 517-03-6202 93 Usual Residence of Decedent "natural", or items 23a or 28a-f show diral Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21043 4475 Montgomery Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Was Decedor...
Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 3 ₺ Widowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Computer Technology Computer Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t, Page 1 and 2 should be fill thent of Health and Mental rant; If item 27 is marked or and Mental Edmund Thompson Dorothy Alice Van Eman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4517 43rd Place NW Washington, D.C. 20016 Sakina B. Thompson/daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit, Page 1 Department of Important: If it any Injury or o cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 07/23/10 4 Donation 5 Other (Specify) Woodbine, MD Signature of Funeral Service Lice Going Holles Cremation Service P.O. Box 784 P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a co or Attending Physician: The law requires that the death certificate be executed the bunial-transit Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No should be detached for Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24 hours after death.

Funeral Director; After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) the funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No M Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) eted filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the within To the 29b. Signature and title, 2

State Registrar 31. Date filed (Month

gistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	te of Mary		artment of <i>rtificate of</i>	Health and N * <i>Death</i>		ene g. No.2 N	10	21.570
			Decedent's Name (First, Middle, Last)					2. Date of Death Month		Year	3. Time of Death
F	hysicia/ Medic/		Eleanor Ed	ina Tipp	et				6, 201		11:45 P ^M
) E	Examin		4a. Facility Name (If not institution, give street a				or Location of Death		4c. County o		
Ar.			National Lutheran Hor		a una lant histhelau		ckville	8. Date of Birth	Mot	ntgor	mery place (State or Foreign
	uneral		5. Social Security Number 6. Sex		n yrs. last birthday 91 Yrs.	Months Days		June 28,		Cour	onsin
_	rector	}	358-14-1568 Usual Residence of Decedent		71			Julie 209	IJIJ V		
yland	how		10a. State 10b. County	10	c. City, Town or L	ocation				1	10d. Inside City Limits 1 Yes 2 No
e ⊠	3a-f s	cto	Maryland Montgomery		Rockvill						
# #	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W		ntry?
ath w	s 23a	eral	9701 Viers Drive	s Decedent Ever	rinll 9		20850	pecify Yes or No-		S.A Americ	can Indian,
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	id other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	Funeral	Arr	ned Forces? Yes 2 ☐ No	1943		Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)		k, White,	
036 Jrs af	al", or	ğ	If Y	es, Give ar or Dates:	1948	1 □Yes 2 N	o Specify:		Specify:	W	hite
2 P	natur lical I	Completed	15. Decedent's Education (Specify only highest grade comp	eleted)	l (Giv	edent's Usual Occ	e during most of work		6b. Kind of Bu	siness/fn	dustry
ight	nan "	ηdμ		llege (1-4or 5+)	· life.	DO NOT use retir	red)		0	11	
d 21 filed w Hygie	her t	ပိ	12 17. Father's Name (First, Middle, Last)			Homem		ne (First, Middle, M		wn <u>Ho</u>	ome
Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mental Hydiene.	c eve) Be	Louis Stahlbuse	eh.				harlotte			
arylan should be ind Mentai	mark	ဍ	19a. Informant's Name/Relationship (Type. Pri		19b. Mai	ling Address (Stre	et and Number or Ru				p Code)
	n 27 is marked o er traumatic eve		Charlene Rodriguez/Da		120	04 Scove	11 Terrac	e, German	ntown, l	MD 2	0874
O - I	등등		20a. Method of Disposition	- 1	20b. Place of Disp cemetery, cre	position (Name of ematory or other politan	lace)	Date 2	20c. Location -	City or To	own, State
altimore, rmit. Pages 1 ar	ant: If ury o		1 ☐ Burial 2 ■ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State	Cremato	rium	July	19,2010	Alexan	dria	, Virginia
Balt permit.	Important: If it any Injury or o		21. Signature of Functor Service Licens 19	and a	*	Moleswor 26401 Ri	ress of Facility th-Willian dge Road,	ms, P.A., Damascus	Funera MD 20	a1 He	ome
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one clu	s that caused the	e death. Do not e	nter the mode of d	lying, such as cardiac	or respiratory arre	est,		Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition		stive Hea						Onset and Death
	edical		resulting in death)	Due to (or as a co	onsequence of):						
Exa	miner	_	Sequentially list conditions, b.	Due to (as an a a	anaguana afi:					-	
ted *	nsit	nine	Cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence or).					- 4	
, execu	n and al-tra	Examiner	that initiated events c	Due to (or as a co	onsequence of):						
8760, icate be executed	physician and the burial-transit	dical	d								
68 rifical	ng phy as th		IE EENALE.				-				
. Box 6	attending for use as	Physician/Me	in the past 12 months?	/es, outcome of p ☐ Live birth 2 [Fetal death 3	☐ Ectopic pregna			23d. Dat Mo		very Day Year
be de	by the a tached fo	/sici	1 🗆 Voo 2 🐯 No 4	☐ Pregnant at tir ☐ Unknown	me of death 5	☐ Other (specify))				
rhat #	de de		Part II. Other significant conditions contributi	ng to death but r	not resulting in the	underlying cause	given in Part I.	23e. Did tob	acco use cont	ribute to	the cause of death?
ds,	E 9	d by	Dementia					1 🗆 Ye	s 2 No	3□ Pro	obably 4 🖪 Unknown
N red	s been signal	Completed						24a. Was a	n 24b. \	Were aut	topsy findings available
B ea	cate has	dwo						autops perform 1 🗆 Yes 2	ned?	death?	completion of cause of 2 No
<u>a</u> ::	certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only on	102		
f (.≌ ≒		examiner? 1 ☐ Yes 2 Mo	ıl: 1 □ Inpatient	2 🗆 ER/Outpati	ent 3 DOA		lome 5 ☐ Reside	ence 6 DOth	er (Spec	cify)
D E	After th funeral	.iio	27. Manner of Death 28. 1 ■ Natural 5 □ Pending	 a. Date of Injury (Month, Day, Y 	/ear) 28b. Time		njury at Vork?	28d. Describe ho	ow injury occurr	red	
vision of Vital Records, P.O Attending Physician: The law requires that the releath.	tor: A	cati	2 Accident investigation	Diese of Injury	At home form		□Yes 2□No	28f Location (St	troot and Numb	er or Ru	ral Route Number,
Division of Vital Record Lor Attending Physician: The law require after death.	Director: d in by the	Certification: To	4 Homicide determined	building, etc. (- At home, farm, s (Specify)	street, lactory, onic	.6	City or Town	n, State)	er or riu.	rar riodic rearricos,
Hospita 24 hours	To the Funeral Directory Completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: 0	: To the best of r On the basis of earth	xamination and/or	ath occurred at the investigation, in m	e time, date and plac ny opinion, death occ	e, and due to the durred at the time, d	cause(s) and m late and place,	anner as and due	stated. to the cause(s)
ro the	Fo the comple	Mec	29b. Signature and title of certifier			29c. Lice	ense number	2	.9d. Date signe	d (Month	ı, Day, Year)
			multer.	an			00064624		Ju	1y 1	7, 2010
			30. Name and address of person who complete			e, Print)					
6 t	IVA		Sandeed Sharma, MD	743 S 32. Registrar's		alk Drive	, Gaither	sburg, MI	20878		
i	Sta Registi		31. Date filed (Month, Day, Year)	P 275 2017	s Signature	backs	/				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 23a per dr., g906,08/04/2010dhb, Certificate of Death Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Kenneth Aubrey Tyson Julv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Homewood at Crumland Farms Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹M 2 □ F Months Days Hours Min. June 18 Year 1925 85 Maryland 218-26-2959 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Frederick Maryland Frederick X ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 21702 U.S.A. 2507 Coach House Way, Unit 3A items ; within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian was Decedent Ever in U.S. Armed Forces? 1 M Yes = 2 No If Yes, Give 1943-1946 Year or Dates. Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White "natural", 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) United Methodist Clergy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Sarah Gladden Elmer L. Tyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2507 Coach House Way, 3A, Frederick, MD 21702 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Mrs. Lois F. Tyson, wife other i 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Dulaney Valley Mem. Gardens July 6 1 Burial 2 Cremation 3 Removal from State 2010 Timonium, MD 29, injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Linense Reeney and Bastord PA Funeral Home any M00255 106 East Church Street, Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracranial Hemorrage **ICH** disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Brain Tumor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death g Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🔲 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XXNo 1 🗆 Yes XX No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: XX Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**XX**No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
XX Natural 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who con

AUG 0 4

use of death (Item 23a) (Type, Print)

gampola

006881

196

Thomas

29d. Date signed (Month, Day, Year)

July 23, 2010

		1	For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1									21,572	
	Physicia	n/	1. Decedent's Name (First, Middle, Last								2. Date of Death Month Day		3. Time of Death	
	Medic Examin	al .	Nellie Cecelia Warren 4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death			July 13, 2010 3:19 4c. County of Death			_3:19 P _ ^M	
	LXaiiiii		Holy Cross Hospital			Silver Spring If Under 1 Year If Under 24 Hrs.			Montg					
	Funeral Director		5. Social Security Number 6. Se 215 38 6833	x □ M 2 XX F	7. Age (In yrs. 1	last birthday) Yrs.			f Under 24 Hrs. 1 Hours Min.	8. Date of Birtl (Month, Day Sept 8,	1939	9. Birthp Count Mary	elace (State or Foreign try) and	
_	how at	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loc	ation					1	0d. Inside City Limits	
	Marylar 28a-f s otified		Maryland Prince George's Upper Marlboro											
	ith the 23a or 2 st be no	ral Di	10e. Street and Number 6604 Pepin Drive					2077	72		10g. Citizen of Unit	What Cour		
	s after death w ral", or items: Examiner mu	Fune	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13. V	/as Deceder Yes, specif	nt of Hisp	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)		ce - Americ		
036		ed by	1 Never Married 2 Married 1 Ses 2 MNo If Yes, Give Year or Dates.				1 ☐ Yes 2 ☐ No Specify:				Specif			
2-0	72 hour matur edical	plete	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give					done dun	on ing most of worki	ng	16b, Kind of Business Industry			
212	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Elementary/Seconday (0-12)	College (1	i-4 or 5+)		NOT use r	etirea)			Self	Employ	red	
Maryland 21215-0036		To Be	17. Father's Name (First, Middle, Last) James L. Miles				18. Mother's Name (First, Middle, Maiden Surname) Nellie Curtis							
ary			19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing					g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
			Robert Warren (Husb	and)	20b.	6604 Place of Dispo			Upper Mai	rlboro, M	D 20772 20c. Location	- City or To	own, State	
Baltimore,			1 Burial 2 Cremation 3 4 Donation 5 Other (Specific			cemetery, cren	atory or oth	ner place)	metery 7,			-		
Balt			21. Si Funeral Service Leas	de Me Ma	- 9	1/3 22					ome,Inc	6633 01	d Alexandria	
Ė			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between											
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	a	Acute Pr							_	Onset and Death	
	Examiner		Sequentially list conditions,	b ———	(or as a consec	on Induc	ed Inn	mosur	pression					
-	ed sit	Examiner	duste (or as a consequence of cause (Disease or injury)											
	cate be executed physician and the burial-transit		that initiated events C. Due to (or as a consequence of):											
200		edical		d										
89 ×	h certifi tending ir use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		3 ☐ Ectopic pregnancy			23d. Date of Month		ate of deliv	ery Day Year			
Division of Vital Records, P.O. Box 687	ne deat y the at ched fo	Physician/Me	Time past 12 Months 1								WORTH Day real			
P.0	s that tigned by	by	Part II. Other significant conditions contributing to death per not resulting in the enderlying eaces grown at a con-								23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🏋 Probably 4 ☐ Unknown			
ords	The law require ate has been si page 2 should	leted								24a. Was	an 24b	. Were auto	psy findings available	
Rec		Completed	N -50-2-							autor perfo	osy rme v i? 2 █ No	death?	mpletion of cause of	
ita	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2] FD/O: tti		Lou	e of Death (Check		C C O	har (Passif	A.	
of <	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ate: To	27. Manner of Death 1 ♣ Natural 5 ☐ Pending	28c. Injury at work?			me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
sion		Certificate:	2 Accident Investigation 3 Suicide 6 Could not be					M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Number,			
<u> </u>														
		Medical	29a. Certifier 1 A Certifying Physic (Check 2 Medical Examionly one) 3 Certifying Nurs	ner: On the ba	asis of examination	on and/or inves	igation, in m	ny opinion,	death occurred a	t the time, date a	ind place, and c	lue to the ca	use(s) and manner stated.	
_		_	29b. Signature and title of certifier					29c. License number			29d. Date signed (Month, Day, Year) July 14, 2010			
			30. Name and address of person who d	ompleted cau	use of death (Ite	m 23a) (Type, F	F	לכת			JU.	Ly 14,	2010	
Shailesh Sheth, M.D. 1500 Forest Glen Road, Silver Springs, MD 20910														
	State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Auril Auril 32. Registrar's Signature													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jul v 7:00 а.м Physician/ Calvin Harrington Windsor 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Crocheron 1538 Bennett Road 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral July 26 Hours 1934 Maryland 212-40-9425 76 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 Yes 2 X No MD Dorchester Crocheron 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21627 USA 1538 Bennett Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. þ 1 🔀 Never Married 2 🗌 Married Yes 2 X No Baltimore, Maryland 21215-0036 white ☐ Yes 2X No Specify Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) seafood waterman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Austin Windsor Eulalia Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1538 Bennett Road, Crocheron, MD Joyce A. Jones p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory of Delmarva 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/30/10 Delmar. DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician, disease or condition resulting in death) Oans Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an After this certificate has page 2 autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural work 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Avene

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Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ $\operatorname{JuIv}^{\scriptscriptstyle\mathsf{Month}}$ 16 2010 5:45 p.™ John Richard Warfield Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Chesapeake Woods Center Cambridge If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth Funeral March 14,1926 1 X M 2 - F Mary Land 84 213-24-4943 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director Dorchester Cambridge 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA items 23a 1007 Hudson Road 21613 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black White, etc. 1 X Yes 2 No. 1f Yes, Give 1952-54 Year or Dates. 9 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. white 'natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) seafood waterman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ Cora Marshall George Warfield 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Hudson Road, Cambridge, MD f Health item 27 Mary Frances Warfield wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 7/20/10 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part DEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) DYANCED Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 2 No Unknown sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 № Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 🖪 Natural 5 \square Pending 1 Yes 2 No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu Accident Investigation 6 Could not be Accider
Suicide 3 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 69234 30. Name ar address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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ERRABO LU

STREET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		•	State Registrar		,	Cert	tificate of L	Death	,	Reg. No	o.	
	Physicia	ın/	1. Decedent's Name (First, Middle, La	•					2. Date of De		ay Year	3. Time of Death
	Medic	al	Steven John Wo								2010	10:05 AM
	Examir	er	4a. Facility Name (if not institution, given Casey House	e street and number)			4b. City, Town, or Rockvil	Location of Death	1		c. County of Death	7
	Funeral			Sex 7. Age	e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	g. Births	place (State or Foreign
	Director		216-58-9424	1 🕅 M 2 □ F	58	Yrs.	Months Days	Hours Min.	Nov 22	y 13	51 Iowa	try)
Ę.	at	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County	-	10c. City.	Town or Loc	ation				1	0d. Inside City Limits
arylar	farylar 3a-f s iified		MD Montgom	orv	,	mantow						1 ☐ Yes 2 👿 No
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Director	10e. Street and Number	ETÀ	GCLI	ilaircow	10f. Zip Code			10g. C	itizen of What Cour	ntry?
		Funeral	19902 Waterl∞ C	ourt			20874			US	A	
death	item Jer m		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.		as Decedent of H	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	-	14. Race - Americ Black, White,	
36 after	al", or xami	Completed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 🕅 Yes 2 🗌 If Yes, Give Year or Dates.		72 1	☐ Yes 2 🛛 No	Specify:			Specify: Whit	
5-00 hours	natura ical E	lete	15. Decedent's	Education	1970-	16a. Decede	ent's Usual Occup		- V	16b, F	Kind of Business In	
21.5 12 12 12 13 14	e. han "ı Med	l mo	(Specify only highest of Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. DC	NOT use retired)	during most of wor	king	l		
<u>7</u>	lygier ther ti nt, th	Be C	12			Lette	r Carrie			_	Postal S	ervice
anc be file	ental F ked of	To B	17. Father's Name (First, Middle, Last Russell Edwin Wo					18. Mother's Nan Evelyn				
Jary I	and Me is marl aumati		19a. Informant's Name/Relationship			19b. Mailing	Address (Street a				r Town, State, Zip (Code)
e, Marylan and 2 should be fil	altha n 27 is ertra		Linda L. Woltz/w	ife		١ .	,				MD 20874	*
ore e 1 an	of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	Removal from State	20b. Pla	ace of Dispos metery, crem	ition (Name of atory or other place	e)	Date	I .	ocation - City or To	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	tment tant: ijury c		4 Donation 5 Other (Spec	cify)	Fina	l Jour	ney Crem	atory 07	/23/10	Woo	dbine, MI	
Bal	Department Important: If any injury or once.		21. Signature of Funeral Service Licensele College MO1251 Beverly L. Heckrotte, P.A. Clarksvil									
	197		23a. Part 1. Enter the disease, or con	mplications that caused							arksviiie	Approximate
Phy	ysician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line Metasta								Interval Between Onset and Death
)	Medical		disease or condition resulting in death)	Due to (or as a			arcer					<u> </u>
E)	kaminer	Ļ	Sequentially list conditions,	b. —								
D	.it	nine	if any, leading to immediate Cause Enter Underlying Cause (Disease or iinjury	Due to (or as a	conseque	ence of):						
xecute	and al-tran	Еха	that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):						
o pe e	physician and the burial-transit	Medical Examiner		■ d								
8760 tificate b	D &	Med	IF FEMALE:									
X 6	attendir for use		23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy							23d. Date of deliver	ery Day Year	
P.O. Box 68760 that the death certificate be executed	the a	Physician/	1 Yes 2 No	4 Pregnant at 9 Unknown	time of de	ath 5 □	Other (specify)				Mortu	Day Teal
P.O	been signed by the s should be detached		Part II. Other significant conditions	contributing to death b	ut not resul	Iting in the un	derlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to th	ne cause of death?
	an sigr uld be	ed b							1 🗆	Yes 2	□ No 3 □ Prol	pably 4 🛚 Unknown
Records, The law requires	has bee ge 2 sho	Completed by							24a, Was		24b. Were autoprior to co	psy findings available mpletion of cause of
Re la	ate pag	Com								ormed? 2 ♣ N		
tal cian:	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Chec			37	
F VI	this or	2	1 Yes 2 XNo 27. Manner of Death	1 Inpatie		R/Outpatient 28b. Time of		4 L Nursing H			Other (Specify	hospice
Division of Vital Records, alor Attending Physician: The law requires	th. After funel	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day		injury	28c. Injury work M 1 🗆	/aι ? Yes 2 □ No	28d. Describe I	now injui	y occurred	
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ital or	urs aftu ral Dir lled in			building, etc	. (Зреспу)				City or Tov	vn, State) 	
Hosp	24 hou Funei sted fil	Medical	(Check 2 Medical Exar		camination a	and/or investig	gation, in my opinio	n, death occurred a	at the time, date a	and place	e, and due to the car	use(s) and manner stated.
o the	within 24 hours after death. To the Funeral Director: After this certific. completed filled in by the funeral director,	Σ	only one) 3X Certifying Nu 29b. Signature and title of certifier	rse Practioner: To the	pest of my l	knowledge, de	29c. License		ce, and due to th		s) and manner as st te signed (Month, I	
	/ F U		1.00	a (M. D.	220	(120)	R1206	98			y 20, 201	
12	×		30. Name and address of person who			23a) (Type, Pr	int)					
10			Nicole Christens				r Mill R	d. Rockv	ille, M	208	855	
	Stat Registra		31. Date filed (Month, Day, Year) JUL 2 3 2	010 32. Registra			aked					

State of Maryland / Department of Health and Mental Hygiene
State Amended #8 per FH, RG FCHD 7/22/10.
Registrar

State of Maryland / Department of Health and Mental Hygiene
Registrar

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day JOHN TOTTEN WEAVER July 2010 12:57 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1947 1 ₹ M 2 □ F 63 Director 164-36-9993 /irgińia Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 🔀 No Maryland | Frederick Point of Rocks 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21777 United States 4127 Rockhall Road or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2

No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify. Specify: white "natural", 3 Widowed 4 Divorced Year or Dates Vietna Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. **7 is marked other than "n** (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Railroad Track Inspector Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ဂ Edna Louise Totten <u>James Wilson Weaver</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1073 Hammonds Mill Rd., Hedgesville, W, 25427 Nancy Woods (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory July 21,2010 Hagerstown, Maryland 21. Signature of Funeral Service Licensee Relneyd & Basford Funeral Home P.A. 106 East Church Street, Frederick, Maryland,21701 MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes icate has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1X Naturai thin 24 hours after death.

the Funeral Director: At mpleted filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the 29b. Signature and title of certifier 29c. License number 2010 MDD 35106 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add es 4Q0 Frederick, mo 10 Myung 32. Regist ar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 Donald James Wilkins 12:45AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1245Am Rockville Shady Grove Hospital Montgomery 8. Date of Birth (Month, Day, Ye Nov. 28) g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Washington, Hours 1 XM 2 F **Director** 228-54-3493 67 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Montgomery Germantown 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 7/15/2010 Funeral 23a 18003 Mateny Road # 411 20874 United States , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Cau<u>casian</u> "natural", 3 Widowed 4 Divorced Vietnam Year or Dates. Date of Death permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Information Tech. Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Lawrence Wilkins Mildred Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Victoria Lynne Wilkins, Daughtdr</u> Meander Cove Dr. Germantown MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Everly Crematory 7/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Signature of Funeral Service Licensee M01463 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, shock, or heart failure. Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest t only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ MIDURS disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Cardio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events at initiated events. Due to (or as a consequence Exami or Attending Physician: The law requires that the death certificate be executed g B Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No ate has been signed by the page 2 should be detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No this certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 1 No ၀ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 🗹 Certifying Physician: To the þest of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the days of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Praction of To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 20068207 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE CENTER DRIVE KEUA. 4901 MEDICAL MID 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:30 P M 2010 23, Darwin Younker July Bruce /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 10813 Clinton Avenue Hagerstown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Year) Months 1 X M 2 □ F 2,1947 Maryland Director 219-46-3647 63 March Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exammer was beneaited at 1 ☐ Yes 2 X No Director Washington Hagerstown Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 10813 Clinton Avenue 21740 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify If Yes Give Specify: 1968 White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crane Manufacturer 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ae Lucille Virginia Cross Bruce Onal Younker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) M4C5K8 110 Gledhill Avenue Toronto, Ontario Dawn Reilly - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkhead Cemetery July 28,2010 Parkhead, Maryland 21795 Osborned Admenadity Home, P.A. 21. Signature of Fyneral Service 425 S. Conococheague St.Williamsport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition as CEREBAL VASWIATE ACCIDENT Onset and Death (- 1) F **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed and Due to (or as a consequence of) burial-1 Box 68760, attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) □Yes 2□No P.O. the 9 Unknown signed by the 23e. Did tobacco ase contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 ☐Yes 2 ☐ No 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred medica examiner? 26. Place of Death (Check only e) funeral director, Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖳 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director Afte completely filled in by the fune 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and

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State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of per

32. Registrar's Signature

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of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2:15 a^M Alchin Gloria Mae August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Rosedale Franklin Woods Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 213-46-4207 Months Hours Min. Maryland 84 Director ecember Usual Residence of Decedent vartment of Health and Mental Hygiene. oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Dundalk Baltimore Md. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic aware the Mariania. Funeral 21224 USA 718 South 49th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give White Specify: 3 Widowed 4 X Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. Social Services Home Management Aide 12 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ruth Smithson Harry Alchin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3721 Washington Ave. Abingdon, Md. 21009 Jeff Jolliffe Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 7, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5 Other (Specify) 4 Donation Dundalk, Maryland Oak Lawn Cemetery Connelly Funeral Home Of Dundalk, P.A.

Connelly Funeral Home Of Dundalk, Md 21222 Stonature of eral Service Licenses 7110 Sollers Point Road, Dundalk, 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due the as a consequence of disease or condition resulting in death) Medical Examiner Siseas Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and thed for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 🗌 Yes 2 🗎 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2. No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

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erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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MD

Registrar

State

30. Name and address of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM# 4a, perPHYS, G906, 87672010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:35AM **Physician** nice Duie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)

*Cood Samaritan Hospital 4b. City, Town, or Location of Death Examiner Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7-23-45 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 □ M 2 🛛 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Depariment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at RaHiMore 1 XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Klack 1 ☐ Yes 2 📉 No Specify: þ 3 ☐ Widowed 4 ★ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life OO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland 21 18. Mother's Name (First, Middle, Maiden Surname Father's Name (First, Middle, Last) Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Street RaHiMore Pages 1 and 2 Date 20b. Place of Disposition (Name of cemetery, crematory of other p 20a. Method of Disposition Baltimore 1 Burlal 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State York Road 21. Signature Luner LS ry Licensee Maryland 2015 Balti More, 23a. Part 1. Enter the disease, or complications that caused the death. Do not entertible mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death S Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown 2 🗌 No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0069314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**The Complete Cause of Death (Item 23a) (Type, Print)

**The Complete Cause of Death (Item 23a) (Type, Print) 5601 Loch Raven Boulevard, Baltimore Maryland 21239 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar Certificate of Death Reg. No.	450
Physiciar Medical Examin	1/	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of December 1. December	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center 4c. County of Death Harford	
Funeral Director		5. Social Security Number 213-04-4108 6. Sex 7. Age (In yrs. last birthday) 44 Yrs. 16 Under 1 Year 1 If Under 24Hrs. 17 Under 24Hrs. 18 Days Hours Min. 10/04/1965 Foreign Country Months Days Hours Min. 10/04/1965 Foreign Country Manual Processing Coun	
Maryland 28a-f show any d at once.	ľ	MD Harford Bel Air	de City Limits
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 924 Richwood Ct. 10f. Zip Code 21014 10g. Citizen of What Country? USA	
er death wi	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No specify: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indiar White, etc. White	n, Black,
215-0036 be filed within 72 hours mal Hygiene. ent, the Medical Exam	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)	on
21215-0036 Mental Hygiene marked other than c event, the Medica	æ	William Harry Boss Zetta Geneva Smith	
MD and 2 sho alth and 1 is 7 is		Darlene Bitzer/Sister 1316 Third Rd. Baltimore, MD 21220	
Baltimore, permit. Pages 1 as Department of He. Important: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem. 20c. Location - City or Town, State Aug. 4, Beltsville, Chesapeake Crem. 21. Signature of Funeral Service Licenspee 22. Name and Address of Fact AFA/Stephen D. Lohrmann.	
Physician	ł	Melocca Aackernon 8717 Green Pastures Dr. Balto, MD	21286
/Medical Examiner	1		en Onset and Death
***	Jer	Sequentially list conditions, if any, leading to immediate bue to (or as a consequence of):	
ecuted	Examiner	Course. Enter Underlyting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
60, te be exect ysician an burial - tr	Medical	☑ UNPENDED ☐ AMENDED 23a,27,28a-f per me g906 8-17-10 vt	
	Physician/M		Year
, P.O. I res that the signed by the detache	6	1 Yes 2 ✓ No 3 Probably 4	
tal Records, ian: The law requires certificate has been sector, page 2 should	Completed	24a. Was an autopsy find prior to completion death? 1 ✓ Yes 2 No 1 ✓ Yes	
Vital Vital ysician: his certifi director,	a Re	25. Was case referred to medical examiner? 1 V yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other.	
After th	ᇎ	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
Division of To the Hospital or Attending Ph within 24 hours after ceath. completely filled in by the Attending	Certification:	Accident 3 Suicide 6 X Could not be determined 6 Accident 3 October 10 Suicide 10 Suicid	
To the Hospi within 24 hour Completely fill	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To wit To cor	Me	and manner stated. 29b Signature and title of certifier 29c. License number O.C.M.E. August 2, 2010	'ear)
pand	}	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra		31. Date filed (Month 1979, Year) 32. Registrar's Signature	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ BEOWN UNICE Medical or Location of Death 4c. County of Death , give street and number) 4a. Facility Name (if not institution, **Examiner** Harview Jaltimore led If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Min (Month, Day, 1 M 2 XF Yrs. **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Baltimore 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number Funeral 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. Black If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry //Seconday (0-12) College (1-4 or 5+) House Keepina Be Nother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Smith Williams 19a. Informant's Name/Relationship (Type, Print Mailing Address (Street and Number or Ru ral Route Number, City or Town, State, Zip Code permit. Page 1 and:
Department of Heali
Important: If item 2
any injury or other Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Raltimore, Marylang Zion 10 2010 Mount 4 Donation 5 Other (Specify) 4405 York Road Kultimore, Haryland 21212 Sign up of uneral Servi Licensee 22. Name and Address of Facility pproximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart fature. List only one cause on each line. mot enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final System ATHEROSCIOCOTIL VASCULUR DISCHIE Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DIABUTES MOLLIPUS Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 30 4P32T5N5106 The law requires that the death certificate be executed and use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ☐ Pregnam ☐ Unknown been signed by the a should be detached t the g Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC PALLUME RENKL 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform 1 Yes 2 No certificate Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA 1 Inpatient 2 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural iniury 5 Pending 2 🗌 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BMJUMD 212/8 MORAN 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Veal Claudia Ann Boyle 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3822 Bayville Road Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

MD . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 01.27.1941 1 □ M 2 😿 F 69 217.38.2548 Director Usual Residence of Decedent or 28a-f show be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore MD Baltimore 1 Yes 2 No . 23a c. ⁺ be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23 dical Examiner must 3822 Bayville Road 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced ed win.
I Hygiene.
I er than "nat...
Nedical Ey Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 1 and 2 should be filed w if Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Milburn Claudia Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Boyle/Husband 3822 Bayville Road, Balto., MD 21220 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 08.06.10 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 61443 8717 Green Pastures Dr. Balto., MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death GASTROINTISTINAL STRONAL TUMOR Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to improve Examine Due to jor as a consiquence of if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? detached for 5 Other (specify) Month Dav Year Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> pe Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(\sum \) Nesidence \(6 \sum \) Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 \square Pending Hatural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AUGUST 5, 2010 00058475 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9114 PITICADE CPHEA NO BACTIMONS MO MIR 31. Date filed (Month, Day, Year) State AUG 0 6 201

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2010 9:10 Dorothy Elizabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1609 N. Chilton Street Baltimore na 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year) 3-31-1940 1 □ M 2 🕱 F Days Hours Min. 241-56-0284 N.C. **Director** 70 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State Director Yes 2 No Baltimore MD na 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21218 S Α 1609 N. Chilton Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc Armed Force Be Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) lementary/Seconday_(0-12) College (1-4 or 5+) Bank of America Data Entry 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Mary Allen Carl Raynor 19a. Informant's Name/Relationship (Type, Print) Daughtet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 Stephanie B. Timbers-5629 Frankford Avenue Apt Cl Balto, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 7-23-2010 4 Donation 5 Other (Specify) Oaklawn Cemetery Balto, MD Signature of Funeral Service Licenses March East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1, End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ aryngea disease or condition resulting in death) a Medical Due to (or as a contequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No 1 🗌 Yes 4 Nursing Home 은 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best or my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29c. License number altim

Registrar DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

31. Date filed (Month, Day, Year)

NAMe Known to Physician: Blown, Eddie Louis Baltimore, Maryland 21215-0036

	Pity N Exa	
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the financial director, nane 2 should be detached for use as the burial-transit

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Examin		4a. Facility Name (if not in			·	<457FM	4b. City, Town, or		eath	4c. Count	y of Death	-
Funeral Director		5. Social Security Number 245–12–086	f 6. Sex		Age (In yrs. la		If Under 1 Year Months Days	If Under 24 H	drs. 8. Date of Bir (Month, Date of Box) Dec 30	th	g. Birtho	lace (State or Foreign ny) h Carolina
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the Mar a or 28a be notifi	Funeral Director	Maryland (10e. Street and Number	Cecil			Perry	10f. Zip Code			10g. Citizen of		1 Yes 2 No
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ I		Armed Force 1 N Yes 2 If Yes, Give Year or Date:	□ No 15	955	f Yes, specify Cuba ☐ Yes 2 🎇 No	n, Mexican, Pu			ack, White, e	tc.
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permit. F Departm Importa any inju		21. Signature of Funeral		Thomas		r 22	Name and Addres	Societ	v Of Marv	land, I	inc.	
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ling Phy .r After thi funeral o			Pending	28a. Date of		28b. Time of injury	28c. Injury work	at ?	28d. Describe h			
or Attencation after deati	Certificate:	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not be determined		Injury - At ho etc. (Specify,		M 1 L	Yes 2 □ No	28f. Location (S City or Tou	Street and Numl vn, State)	ber or Rural	Route Number,
Hospital	Medical	(Check 2 🔲 M	ledical Examiner	: On the basis	of examination	and/or invest	igation, in my opinic	n, death occurr	e, and due to the ca red at the time, date a d place, and due to th	nd place, and de	ue to the cau	se(s) and manner stated.
To the within To the comp	2	29b. Signature and title	- //	Bung	o ru	0	29c. License		proof, and day to the	29d. Date signe	ed (Month, D	
		30. Name and address of Thomas B	person who com	pleted cause of	of death (Item	23a) (Type, F	rint) D HEAUTE	CARE	system.			
Stat Registra		31. Date filed (Month, Day	(Year)	2. Regi	strar's Signat	ure L	4.1		,	,	1	MD 27902
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State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:55 a M Nora Q. Baxter 04 2010 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 4100 Maple Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, 5, Social Security Number 7. Age (In yrs. last birthday) **Funeral** New York Months Days Hours Min. 1 □ M 2 🕱 F 96 085 03 8552 02/11/1914 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show other tranmatic event, the Medical Examinet must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Funeral Director Baltimore Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 U.S.A. 4100 Maple Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: 2 White 3 XWidowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) High School Secretary 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Quinn Nora Dooley ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21227 4100 Maple Avenue Sister Mary Becker permit. Pages 1 and Department of Health Important; If item 27 any injury or other tr Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 08/10/2010 Matthews, N.C. 4 ☐ Donation 5 ☐ Other (Specify) Lawn East Forest 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 more cations that caused the death. Do not enter the mode of dying, such as cardiac or respir yory arrest, 23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Final **Physician** MYCL disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No for 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. ed by the detached signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 □ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

In Funeral Director: A pletely filled in by the fu death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2. To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific Name and address of person who completed cause of death (Item 23a) (Type, Print) Registr

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Vnthia M	2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "raumatic event, the Mand		19a. Informant's Nan	ne/Relationship	(Type. Print)			19b. Maili	ng Address	(Street ar	nd Number or	Rural Route Nun	nber, City	y or Town,	State, Zip	Code)
	and 2 ealth n 27		KEVIN BY	•	SON							TAMPA				
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70.	t. Pag rtmen rtant: rjury		4 ☐ Donation 5				ME'	TRO.				,2010				A, VA
) Ral	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. Signature of Fun	eral Service Lic	zensee S	5	— МОО	641 5	2. Name ar	wash	or Facility R	AYMOND N AVE.	FUN . LA	IL.SI PLA	ERVI(TA.MI	CE, P.A. D 20646
(7)			23a. Part 1. Enter the shock, or heart	disease, or co	omplications th	at caused	the death	n. Do not en	ter the mod	de of dying	, such as card					Approximate Interval Between
	Physician		Immediate Cause (F disease or condition	inal	., 0.10 00000	,,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5	ene	el!	SULL	w					Onset and Death
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68760	rrificate be executed ing physician and as the burial-transit	Sa E			d											
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0	ires that the de signed by the a		Part II. Other signific	ant condition	s/contribut/la t	o death bu	ut not resu	ulting in the u	ınderlying o	ause giver	n in Part I.	23e. Di	d tobacc	o use con	tribute to th	ne cause of death?
ext Me CM	uires t signe d be	d by		allo	hilles	M		J	, 0			1[∃Yes	2 100	3 ☐ Prot	pably 4 ☐ Unknown
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7	sician: The la certificate ha rector, page 2	Be	25. Was case referre	d to medical							26. Place of [1 ☐ Yes Death (Check onl		NO	1 ☐ Yes	2 L No
t V	Physician: this certific al director,		examiner? 1 ☐ Yes 2 🛣 N	lo	Hospital:	Inpatie	nt 2 🗆	ER/Outpatie	nt 3 🗆 D	Othor		g Home 5 ☐ Re		6 □Ot	her (Specit	5y)
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# 25 h	or At fiter d Direct in by	Certification: To	4 ☐ Homicide	determin	ed 28e. Pi	ace of Inju uilding, etc	iry - At ho c. <i>(Specif</i>)	ome, farm, st	reet, factor	y, office		28f. Location City or	(Street Town, St	and Num. ate)	ber or Rura	al Route Number,
_	Hospital or 24 hours afte Funeral Dir tely filled in	ပ္	29a. Certifier 1	ertifying	Physician: To	the best o	of my kno	wledge dea	th accurred	at the tim	e date and pl	ace, and due to t	he cause	e(s) and m	nanner as s	stated.
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	edical			kaminer: On the		f examina					ccurred at the tin				
	To the within 2 To the comple	Me	29b. Signature and ti	tle of certifie	11	1	7		29	c. License	number		29d.	Date signe	ed (Month,	Day, Year)
				SI	pas (1	mu	0		D-5	17+0	8		//	28	/20/0.
	1/2		30. Name and addre	ss of person w	ho completed	cause of de	eath (Item	23a) (Type	1 -		700	1 000	0	1.	, 11	
	10		Abbas C	Day Vear	11)	enno Begistra	ar's Signa	edica	Lent	er	TC 10	st Uttic	ek	d U	Jaldo	rt, MD
	Sta Registr		AU	G 0 6 20	110	La tend	ar o orgina	ho	well)						2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 129 AM **Physician** Lori A. Black August 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Good Samaritan Hospital Baltimore

ler 1 Year | If Under 24 Hrs. If Under 1 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
Feb. 23, 1964 Maryland 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days 218-94-8798 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State ral", or items 23a or 28a-f show Examiner must be polified at 28a-f show 1 □ Yes 2 □ 🐪 o Parkton MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 18026 Bunker Hill Road 21120 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □No Specify Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shears Hair Stylist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine L. Ford Howard Parks ည Pages 1 and 2 should nent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2506 Rochelle Drive, Fallston, Maryland 21047 Donald Black-spouse Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mays Chapel Cemetery Aug. 6, 2010 Cockeysville, Maryland 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
16924 York Road-Monkton, Maryland 21111 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cancel ina disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Brain Cance Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exam the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl autopsy 2 No 2 40 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation n 24 hours after death.
e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2.

To the F
complete 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number , 2010 30. Name and address of person who completed caused death (Item 23a) (Type, Print) 5601 Loch Raven Boulevard, Baltimore Maryland 21239 00 31. Date filed (Month, Day, 32. Registrar's Signature Year State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mend #17619a Per FH G906 872072010 JH

State of Maryland / Department of Health and Mental Hygien OF Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OUGLAS D. BRACKETT Month **Physician** 1.50 AM 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE RANDA LLS TOWN
If Under 1 Year | If Under 24 Hrs. NORTH WEST HOSPITAL 7. Age (In yrs. last birthday) 68 Yrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Y Jun 12, 5. Social Security Number 263-58-6560 **Funeral** Year) Days Hours 1 □ XM 2 □ F MA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Experient must be notified at ME Caratunk Somerset Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 04925 USA PO Box 95 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 📉 No Specify: White Specify. ⋧ 3 ☐ Widowed 4 Noivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Business Owner Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lijury or other traumatic event once. Be Brackett Brakett Donald Howe Sherlock Eleanor ဂ္ 19a. Informant's Name/Relationship (Type Print)
Brackett
Douglas Howe Bracket/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 Daycotah Ave., Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place)

Final Journey Crem. 1 ☐ Burial 2 【Oremation 3 ☐ Removal from State 08/07/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service License Dorota Marshall centell-basha 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEOMONIA **Physician** MULTI LOBAR /Medical Due to (or as a consequence of) **Examiner** SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner FAILURE MULTI ORGAN and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month been signed by the atte should be detached for Day Year 5 Other (specify) 9 Unknown G I I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Celebrovasculor accidents 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier L, MD D691108 AUM, 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SCBHASH, BOSE, NATICEST NEPTEN, 5401 Old Coust Rd., Randall Stown, MD 21133

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature



filed within 72 hours after

executed

the death certificate be

P.O. Box 68760

Division of Vital Records,

Attending Physician:

Saltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24590 State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 02 Day 2010 8:10 AM HELENE BERGER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL 108 BROOKVIEW COURT WESTMINSTER If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 05/18/1925 85 MD **Director** 216-20-3062 Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland id Mental Hygiene.

marked other than "natural", or items 23a or 28a-f shor 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4730 ATRIUM COURT, #379 21117 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 🕅 Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTING 12 OFFICE MANAGER Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RUDICK SCHWEITZER **JENNIE** 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSIE NEWHOUSE/DAUGHTER 7670 JASMINE DRIVE, WEST PALM BEACH, FL Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 08/05/2010 TOWSON, MD 4 Donation 5 Other (Specify) HILLTOP SERVICE CORP 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) nepable Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day rate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? steaponosis 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge of a coust ist and manner as state 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

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MO

32. Rea

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nanda

Michelle

31. Date filed (Month, Day, Year)

MD

D61043

410 Malcolm Dr Westminster MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08701/2019 9:30 p. M John Shelby Clark Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Cherry Lane Nursing Center Laure1 . Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Days Months 1 X M 2 🗆 F Hours Min. 0271871929 Director 81 Usual Residence of Decedent fshov 10a. State 10c. City, Town or Location 10d, Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No Prince George's MD Laure1 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20708 901 Cherry Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔼 No Yes Give Specify: Completed 3 ₩Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor and Mental Hygie is marked other Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o 2 Elizabeth Mathilda Hood Noah Shelby Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6200 Creetown Dr. Jacksonville Fl. 32216 Roxanne Mangrum- Niece 20b. Place of Disposition (Name of cemetery, crematory or other place 20a Method of Disposition Aug. Date 5, 1 Burial 2 X Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Fune al Service Licensee 933 Gist Ave.20910 22. Name and Address of Facility M00982 Rapp Funeral & Cremation Ser. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ a <u>End Stare Conrestive Heart Failure</u> disease or condition resulting in death) ears Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Universing Cause (Disease or iinjury that initiated events coulting in doub). Let Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred al or Attending F s after death. I Director: After Certificate: 1 XNatural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

P.O. Box 68760 Division of Vital Records, 24 hours a Hospital

> State Registrar

29a, Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 0 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) August 2, 2010

29c. License number

D51051

3621 Ligon Rd. Ellicott City, Maryland 21042

Michael	Joseph	Certeza
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		1- For State Certificate of Death Registrar	F	Reg. No.	1 24596				
Physici Medical Exami			2. Date of Dea Month August 3	Day Year	3. Time of Death 1405 hrs				
,		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locati		4c. County of Deat					
		42 Trailwood Road Perry Hall		Baltimore Co					
Funeral Director		214-72-7014 ₁ X _M ₂ F 51 _{Yrs.} Months Days Ho		irth(MM/DO/YYYY) 9. Bi /1958 Forei Co	gn Philippine				
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
1aryland 28a-f show any at once.	ō	Maryland Baltimore Baltimore			1 Yes 2 No				
h the Mary 3a or 28a- totified at	I Director	10e. Street and Number 42 Trailwood Road 10f. Zip Code 21236		U.S.A.					
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Sive Year 1 Yes, Give Year 1 Yes, Sive Year	ican, Puerto Rican, etc.)	14. Race - Amer White, etc. Fili	rican Indian, Black,				
ours af atural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (G	Sive kind of work done	16b. Kind of Business	Industry				
036 ithin 72 hone. one. Tedical Edecical Edecical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Contractor	NOT use retired)	Contructi	on				
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than	Be Co	D.	ther's Name (First, Middle, rothy Murphy	Maiden Surname)					
Z. = 4 2 5 1	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and the street a	Number or Rural Route Nu	mber, City or Town, State	e, Zip Code)				
Z du dalah z ma z		Dorothy Certeza / Mother 8946 Satyr Hill F		re, Marylan 120c. Location - City of					
Baltimore, N permit. Pages 1 and Department of Health Important: If item injury or other trau		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Serv. Corp.	8/5/2010	Towson, Ma					
Balt permit. Depart Import injury		21. Signature of Funeral Service Licensee 22. Name and Address of Fact 1050 York Roi	ad Towson, M		Home, Inc. 04				
Physicían /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	•		Approximate Interval Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death) a Hypertensive atherosclerotic ca	ardiovascular	alsease	Death				
	5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated							
uted nd ransit	events resulting in death) Last Due to (or as a consequence of): d.								
760, foate be executed physician and the burial - transit	Medical	XUNPENDED AMENDED 27, per ME g906 8/23/10 TT							
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed ar death. rector: After this certificate has been signed by the attending physician and by the finneral director, page 2 should be detached for use as the burial - transi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ect	opic pregnancy	23d. Date of deliver Month	y Day Year				
J. Bc t the dez by the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I. 23e. Did to	obacco use contribute to	the cause of death?				
p. P.O			1Ye	s 2 No 3 Pro	bably 4 🗸 Unknown				
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the fineral director, page 2 should the fineral director.	Completed by				utopsy findings available completion of cause of es 2 No				
Vital Reco ysician: The law his certificate has director, page 2 s	BeC	auania 0	ath (Check only one)						
of Vit ing Physic After this uneral dire	의	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Dther4 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at W	Transmig Fishio o	Residence 6 Othe	r: Scene				
on of anding Phath. or: After the funeral	ţi	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2	_	now injury occurred					
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e Place of Injury - At home, farm, street, factory, office building (Specify)	g, etc. 28f. Location (or Town, S	Street and Number or Ru State)	ıral Route Number, City				
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and Medical Examiner:On the basis of examination and/or investigation, in my opinion, death and manner stated.							
FSFS	ž	29b. Signature and title of certifier 29c. License numb	ber	29d. Date signed (Mo	nth, Day, Year)				
		O.C.M.E.		August 4, 2010					
		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 2120	1					
St Regist		31. Date filed (Month, Pay, Year) ALIC 0 6 2010 32. Registrar's Signature and Signat							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24593 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 2010 6:07 P M Thelma Norma Connolley August 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arbutus Baltimore 5125 Westland Blvd 8. Date of Birth
(Month, Day, Year)
Mar. 21, 1918 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Funeral 1 □ M 2 🗓 F Months Days Hours Min. Maryland 216-03-9236 92 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Director Arbutus 1 Yes 2 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21227 5125 Westland Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. or i 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ₩ No Specify: white 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "n Blue Cross/Blue Elementary/Seconday (0-12) College (1-4 or 5+) Data Processor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Norma W. Tolson Thomas Grindell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Maxa Meadows Lane-Forest Hill, Maryland 21050 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Edwardine Baroch-daughter 20a. Method of Disposition 20b Place of Disposition (Name of Date 20c. Location - City or Town, State Moreland Memorial 1 Donation 5 ☐ Other (Specify) Parkville, Maryland Aug. 9, 2010 <u>Park</u> 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 75: 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No g Unknown 1 ☐ Yes ∠ p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SIDGREN SYNDYOME 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After th 28c. Injury at 28d. Describe how injury occurred Certificate: work 1 XNatural 5 Pending 1 Yes Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 6b. Signature a

Registrar /DHMH 17 Rev 7/2009

State

Box 68760

P.O.

2010

21218

Allendive MD

3512

ho completed cause of death (Item 23a) (Type, Print),

Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			for State Registrar	State of Ma		artment of r tificate of I		Reg. I	2010	24594
4	Physici	an	1. Decedent's Name (First, Middle, L	ast)	(0	Idwell	. N	oate of Death Month	Day Year	3. Time of Death 2: 47 A M
	/Medic Examir	al	JUNE 4a. Facility Name (If not institution, g	ive street and number)			r Location of Death		4c. County of Death	7
1	LAGIIII		The Johns Hopkins			Baltimore				
	Funeral Director	V	5. Social Security Number \mathbf{unk} 6	Sex 1 □ M 2 X F	e (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	Hours Min. Fe	Vate of Birth Wonth, Day, Yea b 20, I	9. Birth Cou	hplace (State or Foreign unitryLink
	rland low t		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	e Many 8a-f sh tified a	Director	MD Howa	rd	Laurel					1 ☐ Yes 2x No
	th with th 23a or 2 st be no	ral Dire	10e. Street and Number 10355 Scaggsvi			10f. Zip-Code 20723		U	Citizen of What Cou	intry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2🛣 No			14. Race - Amer Black, White Specify: Wh	e, etc. ite
21215-0036	within 72 ho sne. than "natur e Medical"	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) unk		(Give	dent's Usual Occu kind of work done DO NOT use retired	during most of working	16b	. Kind of Business/l	Industry UNK
and 2	d be filed vental Hygie ced other to cevent, th	To Be Co	17. Father's Name (First, Middle, Las		.		18. Mother's Name (Fire	st, Middle, Maid	den Surname) un	k
2	1 and 2 shoul Health and Me em 27 is mark ither traumation	ř	19a. Informant's Name/Relationship Edward Coldwel	, , ,			and Number or Rural Ro. gsville Road			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 XOther (Spe	□ Removal from State	10	matory or other pla			Location - City or	Fown, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Euneral Service Lice Ronald	Wade bire	ector		ess of FacilityState Baltimore St	-		, MD 21201
	Physician /Medical		23a. Part Enter the disce, or shock, or heart failure. List onl Immediate Cau. Final disease or condition resulting in death)	y one cause on each lin a My (ng, such as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
	ficate be executed the physician and the burial-transit the burial-tra	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	a consequence of):					
68760,	ficate physas the	ledi		11-1			_			
Box (The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	Ctopic pregnand Other (specify)	су		23d. Date of deli Month	ivery Day Year
ds, P.O.	uires that the signed by ald be deta	by	Part II. Other significant conditions	s contributing to death b	out not resulting in the	underlying cause g	given in Part I.	23e. Did tobacc	co use contribute to	o the cause of death?
of Vital Records,	The law require ate has been siç page 2 should	Completed						24a. Was an autopsy performed 1	? prior to death?	utopsy findings available completion of cause of 2 \(\square\$ No
<u>ta</u>		Be C	25. Was case referred to medical examiner?				26. Place of Death (Che	eck only one)		
of \	hysic his ce al dire	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie		IT 3 LI DOA	ner: 4 Nursing Home	5 Residence		oify)
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no	ion (Month, Day	y Year) Injury ury - At home, farm, sti	M 1	rk?] Yes 2 [] No 28f. L	Location (Stree	t and Number or Ri	ural Route Number,
Ď	spital or thours after neral Directory filled in b		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, deat	h occurred at the t	ime, date and place, and opinion, death occurred a	due to the caus	e(s) and manner as	s stated.
	the Hc hin 24 the Fu npletel	Medical	one) 2 Medical Expone)	aminer: On the basis o and manner st		29c, Licens			Date signed (Monti	
	wit o	~	PRRW	L			S - 000		/31/10	., _ = 571 . 5561/
			30. Name and address of person &	no completed cause of	death (Item 23a) (Type	, Print)	600 Nor	th Wolfe	St, Baltimo	ore, MD, 21287
	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 6 2010	32 Registre	g. Signature	الما				

amend #31 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Per DVR G906 8/06/2010 Jh

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month Day **Physician** P^{M} ALBERE JOSSSAD July 2010 8:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Village Health Montgomery Montgomery Village | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Feb 18, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1⊠M 2□ F 579-12-2738 91 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show event, the Medical Exercitor must be notified at MD Rockville 1 ☐ Yes 2 No Montgomery Director 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or USA 20850 9 W. Chestnut #118 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No or items 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🖾 No Specify: Specify: ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) aircraft unk designer <u>un</u>k 18. Mother's Name (First, Middle, Maiden Surname)Unk 17. Father's Name (First, Middle, Last) 1111k Be မ 19a. Informant's Name/Relationship (Type. Print)
Mary Carroll - wife Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19301 Watkins Mill Road Montgomery Village, Maryland 20886 Department of Health Important; If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 █ Other (Specify) in State 22. Name and Address of Facility State Anatomy Board Kona I 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus Final disease or condition resulting in death) Physician ATTUSHED /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Ö □Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? page 2 Division of Vital 1 □Yes Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; ₱ 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one)

State Registrar

DHMH 17 Rev 1/2001

AUG 0 6 2010

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Typ., Print)

32. Registrar's Signature

Anushiravan Dadgar-Dehkordi 10110 Molecular DR. Ste 206 Rockville,MD 20850

29c. License number

H0051288

29d. Date signed (Month, Day, Year)

7-24-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 **Physician** 2010 03 Florence V. Camm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Hyattsville St. Thomas More Nursing and Rehab Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 04/15/1910 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F VA 100 Director 227-40-5066 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The the dieal Experiment to matthe of 1 Yes 2 No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20012 USA 6702 5th ST NW Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2**X**□No Specify. Specify: ģ Black 3 V Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Temple Family 12 should be filed w h and Mental Hygier Is marked other th 8th Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should b unknown 2 James Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other tra 6702 5th st NW Washington, DC 20012 Florence Sims/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lynchburg, VA Forest Hill Buriatk 08/12/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall March Funeral Home 21. Signature of Funeral Service Licens Tanes 4217 9th ST NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) peans APTERUSCIENONE CANDOVASCULARIZ **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year 1 ☐ Yes 2 No Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Respiratory tail wire Ventil atom Denenden 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1 □Yes 2 No certificate Bilatent prevnovia 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical completely and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eensburg Rd HyaTtsv: 1/2 MD Cu 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Reg. N2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle **Physician** /Medical 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs **Funeral** Days 1 M 2 1 € Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.
m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b, Count ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc, 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 ☐ Divorced Busines Industry Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Elementary (0-12) father's Name (First, Migfole) Last Be 20a, Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Denation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is
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To the Funeral Director has been signed by the first of the first of the first of the physician in
To the Funeral Director has been signed by the first of the f P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0069314 Son

State Registrar

DHMH 17 Rev 1/2001

Woods Rd Parkville MD 21234

30. Name and address experson who completed cause of death (Item 23a) (Type, Print)

Mitto V (2) apart 8613 Walthum

Year)

AUG 06

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24598 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 2:00 A M William Page Dieffenbach August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Brighton Gardens Of Columbia Columbia 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Hours 1 X M 2 □ F 1926 Director 210-16-5355 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matfind of 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 TNo Columbia Howard Marvland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21045 7110 Minstrel Way 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1944 Completed by 1 Never Married 2 Narried Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White 3 Widowed 4 Divorced **1948** Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Electrical Engineer Bendix Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Anne Matilda Dahlgren John Harold Dieffenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 131 Glenn Dale, Maryland 20769 William H. Dieffenbach, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 08/06/10 Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Mary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Years Ph sician/ disease or condition resulting in death) Aortic Stenosis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) anding physician and use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 L. retails.
Pregnant at time of death in the past 12 months? Month Year 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure Completed peen 24b. Were autopsy findings available prior to completion of cause of Parkinson's Disease this certificate has page 2 s autopsy performed' death? 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be isted Other: 4 \square Nursing Home 5 \square Residence 6 \undextbf{X} Other (Specify Hospital: 1 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Priysteam. To the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. соmpleted within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D56531 August 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li 8600 Snowden River Parkway #301 Columbia, MD 21045 31. Date filed (Month, Day, Year) AUG 0 6 2010 State

DHMH 17 Rev 7/2009

Registrar

10-05605	
Douglas Dillon	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Douglas Dillon	State of Maryland / Department of H 1- For State Certificate of Description Registrar	eath Re	eg. No. 2010 24599				
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month July 26, 20	Day Year 2455 hrs				
	4a. Facility Name (if not institution, give street and number) 4b. 0	City, Town, or Location of Death	4c. County of Death N/A				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24Hrs. 8. Date of Bir	rth (MM/DD/YYYY) 9. Birthplace (State or Foreign				
Director	3//-50-1331 1XM 2 F 60 Yrs. 0//26/1950 Country M1Ch:						
nd show any ICE.	10a. State 10b. County 10c. City, Town or Location Howard Ellicott C	City	10d. Inside City Limits 1 Yes 2 No				
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 4520 Stonecrest Drive	of Zip Code 1 21043	0g. Citizen of What Country? USA				
or items 233. must be not	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever	ecedent of Hispanic Origin? (Specify Yes or No specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.				
ural", o	Widowed 4 Divorced in tes, diverted or December 1 163 December 1 1	s 2 X No specify: Jsual Occupation (Give kind of work done	Specify: White 16b. Kind of Business/Industry				
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exat Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of	of working life. DO NOT use retired)	Construction				
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical To Be Comple	Tres 17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, I					
1215 The file ental H arked ovent, the	Gerald Dillon	Ruth Horton	0. 7. 0.4				
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	- 1	dress (Street and Number or Rural Route Num conecrest Drive Elli	cott City, MD 21043				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition crematory or other part Atlantic Ce	place)	20c. Location - City or Town, State Glen Burnie, MD				
Saltin ermit. P epartme mportan njury or	4 Donation 5 Other Specify: 21. Circulature of Funeral Service Licensee 22. Name Gary	e and Address of Facility L. Kaufman Funeral H Washington Blvd., El	Tome at MMP, Inc.				
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the management of the failure. (List only one cause on each line.	Washington Blvd. E1 mode of dying, such as cardiac or respiratory arr	kridge MD 21075 Test, shock, or heart Approximate Interval Between Onset and				
/Me dical Examiner	Death						
je je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
ted Insit Examine	cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
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the death certificate the death certificate by the attending phyched for use as the Physician/M	past 12 months? 4 Pregnant at time of death 5 Other 9 Unknown	(Specify)					
P.O. Es that the gned by the detached	3		obacco use contribute to the cause of death? s 2 No 3 Probably 4 V Unknown				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical E.			psy prior to completion of cause of death?				
ital Recionant The lactor, page		26.Place of Death (Check only one)	2 No 1 Yes 2 No				
F Vits Physiciant this contained tree	Yes 2 No 1 Inpatient 2 Erroutpatient 3		Residence 6 Other: Scene				
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Division o Division o Hospital or Attending 24 hours after death. Funeral Director: Aftered filled in by the funeral of the fu	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, st	actory, office building, etc. 28f. Location (or Town, \$	Street and Number or Rural Route Number, City State)				
Di To the Hospital within 24 hours a To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
F 3 F 3	29b. Signature and title of certifier	29c, License number O.C.M.E.	29d. Date signed (Month, Day, Year) July 27, 2010				
10 Fred	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 21201					
State	te 31. Date filed (Month, Day, Year) 7. Registrar's Signature	A.					
Registra DHMH 17 Rev 1/2001	NOC 0 0 2010 700 101 101		OGME				
2001 17 100V 1720U I	ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23afti, 2 / 28a-i Department of Health and Mental Hygiene Per ind 1,8906, 08706/2010dnb Reg. No. 24600 Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 10 05 AM Daly Percy A.N. 08 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospitul of Bultimore Sinai Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1**X** M 2□ F Months Days Hours 217-66-8728 89 04 29 Director 21 Trindad Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5000 Denmore Ave 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", or item any injury or other traumatic event, if item for item any injury or other traumatic event, if item for item in any injury or other traumatic event, if it is infection Event in any once. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Black þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Rosewood State ementary/Secondary (0-12) College (1-4or 5+) 6th grade Painter Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cyril Daly ပ္ Eugenia Lynch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelah Daly-Wife 5000 Denmore Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 8/6/2010 Woodlawn, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee Mus-Alaham 4300 Wabash Ave, Baltimore, Md 21215 2.a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asphyxia disease or condition resulting in death) Due to (or as a consequence of): Choking Cardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine burial-trans CENTRICAL MAPRICATED BY MEDICAL EXAMINER and resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical attending philor use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 ☐Yes 2 ☐ No. detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ failure. Conquitive heart 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one)

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

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Vital

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death.

To the To the F

funeral (

Pages 1

1XYes 2 No

investigation

6 ☐ Could not be

determined

5 Pending

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 08/01/2010

28c. Injury at Work? 9:15a.m₩ 1 □Yes 2X No

Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 28d. Describe how injury occurred

Subject choked on bolus of food

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2525 W. Belvedere Ave., Baltimore, MD 21215

(Check only one)

29a. Certifier

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Nursing Home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lijun Then 2835 Smith Ave, Shite 203, Billimore, MID 2120 State

Certification: To

31. Date filed (Month, Day, Year)

32. Registrar's Signature

barke <u>AUG 0 6 2010</u>

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0332 AM Physician/ Vasileios Deremperdis August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Bultimore Johns Hopkins Baynew Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 9. Birthplace (State or Foreign Country) GREECE 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** octionth, Par Year 1922 Months 212-55-8118 87 Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at. 10a. State Director 1 Y Yes 2 ☐ No N/A BALTIMORE MD. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number UNITED STATES Funeral 21224 419 S. NEWKIRK ST. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 Never Married 2 😾 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) **FARMING** SELF EMPLOYED Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) OLGA LYMPERIDIS ပ MELETIOS DEREMPEIDIS t and 2 should by the Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 STILES CT., JOPPA, MARYLAND 21085 OLGA GEORGALAS/DAUGHTER or other item 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot OAK LAWN CEMETERY AUG. 6, 2010 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility CHARLES S. Signature of Funeral Service Licenses ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas shock, or heart failure
Immediate Cause (Final
disease or condition Onset and Death Anoxic Brain Injur Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Cardio Dulmanan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death is certificate has been signed by the director, page 2 should be detached ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Hypertension . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: မ Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural al or Attending P s after death. I Director: After t Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bastern Avenue, Baltimore, MD, 21224 Heather A Parsons, MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of Ma	aryland / Dep <i>Cei</i>	artment of F <i>rtificate of E</i>			giene Reg. No 20	10 24602
	Physicia		Decedent's Name (First, Middle, Last)	Facoloni			2. Date of De	ath _	3. Time of Death 12:15a M
	Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Decision 1.						August	4c. County Queen	of Death
ممصوره	Funeral			y e (In yrs. last birthday)	Centre If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	C. Birthplace /State or Foreign
H	Director		216-32-1420	74 Yrs.	Months Days	Hours Min.	oct. 4,	1935	Country) Maryland
	yland -f show ed at	To Be Completed by Funeral Director	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	ne Mar or 28a		Maryland Caroline 10e. Street and Number	Federa	10f. Zip Code			10g. Citizen of V	1 ☐ Yes 2 🕱 No What Country?
	s 23a o		7686 Melvin Road		2163	2		United :	
036	ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show maric event, the Medical Examiner must be notified at.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	unk No	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	Blac	e - American Indian, k, White, etc. White
15-0	72 hour		15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa		king	16b. Kind of Bu	usiness Industry
212	within giene. er thai		Elementary/Seconday (0-12) College (1-4 or 5-	+) Produ	OO NOT use retired) uce Mana	ger		Grocery	Store
and	be filed ental Hy ked oth c event		17. Father's Name (First, Middle, Last) Frank Escolopio				ne (First, Middle, aberto	Maiden Surname)
, Maryland 21215-0036	Ith an		19a. Informant's Name/Relationship (Type, Print) Myrtle M. Escolopio, Wife	19b. Mailii 7686	ng Address (Street a Melvin Ro			r, City or Town, Si	tate, Zip Code) and 21632
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place	· !	Date		City or Town, State
altin	permit. Page Department (Important: If any injury or		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Amanda He	Metro Crei			2010 mation S	<u>Baltimor</u> ociety o	e, Maryland f Maryland, Inc.
ñ	an De	(%) 1	Sand Clasch	29	99 Frederi	ck Road,	Baltimo	ore, Mar	yland 21228
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) Approximation for the mode of dying, such as cardiac or respiratory arrest, and interval Bell Onset and Onse									
	Examiner	<u>.</u>	Secuentially list ronditions	a consequence of):					
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	oue to (or as a consequence of):					
per particular description of the property of								-	
20	cate be physici the bu	edical	d						
BOX 68	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	1 Yes 2 No 4 Pregnant at	2 🗌 Fetal death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d. Dat Mor	re of delivery nth Day Year
у. Э.	at the		g ☐ Unknown Part II. Other significant conditions contributing to death but	ut not resulting in the u	underlying cause giv	ren in Part I.	23e. Did to	obacco use contri	ibute to the cause of death?
as, F	quires then signer and be	ed by	PATHORIOSCIENCTIC CAR	previge cul	ATT THE	CORE	1 🗆	Yes 2 ☐ No	3 ☐ Probably 4 ★ Unknown
Vital Records,	The law rec ate has bec page 2 sho	Be Completed	HYPERLIPIDEMIA				24a. Was autor perfo 1 Yes	osy p rmed? c	Vere autopsy findings available brior to completion of cause of death? Yes 2 No
Ita	sician; certific lirector,		25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	ent 2 ER/Outpatier	Othe	ace of Death (Checer:		C W O#-	er (Specify) Hospice
TO UC	inding Phy ath. r: After this te funeral d	icate: To	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation	y 28b. Time of	f 28c. Injury work	at		ow injury occurre	
DIVISION OF	ital or Atte urs after de ral Directo led in by th	al Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	e Hosp 24 hou e Funer leted fil	Medical	29a. Certifier 1 X Certifying Physician: To the best of r (Check 2 Medical Examiner: On the basis of ex only one) 3 Certifying Nurse Practioner: To the basis of ex	camination and/or inves	stigation, in my opinio	n, death occurred	at the time, date a	nd place, and due	to the cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	MD	29c. License			29d. Date signed	(Month, Day, Year)
			30. Name and address of person who completed cause of de	ath (Item 23a) (Type, F	Print)	DENTO	MI M	D 210	629
	Stat Registra		31. Date filed (Mopth, Day, Year) 42. Registrar	r's Signature	Ke		- / (- 4	, 5. /

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #31 Per DVR (906) and Per DVR (906) amend #31 Pe for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jo Kathv Ellis August 201^{vear} 8:30am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3634 Hilmar Road Windsor Mill Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Hours (Month, Day, Ye 59 200-40-5095 Director 1950 Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕺 No MD Baltimore Windsor Mill 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21244 Funeral USA 3634 Hilmar Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian. Armed Forces? þ 1 Never Married 2 X Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) office management administrative assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lola Marguerite Miller Peter Ilioff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3634 Hilmar Rd., Windsor Mill, MD 21244 Mr. Allan Ellis (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) County Cremation 8-6-10 Sykesville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 MO0769 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 sl autopsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 200 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 욘 1 Inpatient 2 I this s after death.

I Director: After this of in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral Di completed filled in Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Risa Davis Kramer 1380 Progress Way Ste 112 Eldersburg, MD 21784 31. Date filed (Month, Day, Year) State Registrar AUG 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0136 AM 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayview Medica More Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min (Month, Day, Year 1 🗆 M 2 🕱 F 219-32-6848 72 Director Maryland September 22.1931 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c, City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Md. Baltimore Dundalk 1 🗆 Yes 2🗶 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 7048 Belclare Road 21222 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2X No ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White "natural", Specify: Completed 3 Wildowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important. If item 27 is marked other than "natu any injury or other traumatic event, the Medicall any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver Baltimore County 11 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vince Broda Emma Kratz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fran Raines Daughter 7048 Belclare Road, Dundalk, Md. 21222 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 7, ■ Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Ž010 Baltimore, Maryland Signature of Juneral Service 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Board Dundalk, P.A. Sollers Point Road, Dundalk, Fart 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ avonary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Secrientistly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 19 months?

1 Yes 2 No Month Day Yea Pregnant at time of death 5 Other (specify) 1 Yes 2 s been signed by the s should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown No 24b. Were autopsy findings available 24a. Was an , page 2 prior to completion of cause of After this certificate has autopsy perforn death? Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie

State Registrar 10V

31. Date filed (Month, Day, Year)

AUG 06

30. Name and address of person who completed cause of death (Item 23a) (Type,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per dr., g906,08/06/2010dhb

Certificate of Death

Reg. No. For State Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ July Day 2:55P 2010 25 Medical 4b. City, Town, or Towson 4a. Facility Name (if not institution, give street a 4c. County of Death
Baltimore **Examiner** Town, or Location of Death Baltimore Medical Greater Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Days 1 M 2 □ F Director items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Completed by Funeral Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 Yes No Specify: 3 Widowed 4 pivorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than ' College (1-4 or 5+) Mental Hygiene. Be Maryland Mother's Name (First, Middle ဂ္ trancis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is Sister *1*0. Baltimore, Place of Disposition cemetery, crematory od of Disposition 20c. Location - City or Town, State permit. Page 1 a Burial 2 Cremation 3 Removal from State Other (Specify) Funeral Servi 21. Signature any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between and Death Immediate Cause (Final Physician/ 10-1961 disease or condition resulting in death) Medical Due to (or as a cans **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed bage 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 유 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 07/26 signal (Month, Day, Year) 29b. Signature and 0 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Dat

Year!

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24606 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Margaret R. Flinchbaugh 04 2010 August 11:00 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Brightwood Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 21, 1933 6. Sex 7. Age (In yrs. last birthday, **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ X F Director 216-28-5221 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location ns 23a or 28a-f show must be notified at 10d. Inside City Limits Directo Baltimore Lutherville 1 ☐ Yes 2 X No Md. 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or iury or other traumatic event, the Medical Examiner must be in 515 Brightfield Road 21093 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Frederick H. Rippelmeyer Marjorie Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Skip Lichtfuss/ Son 20 Lochmoor Ct. Lutherville, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hillton Service Co. 8-6-10 4 Donation 5 Dother (Specify) Towson, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Funeral Service License 1050 York Rd. Towson, Md. 21204 23a. Part1. Einer the disease, or coun cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Storge End Demention Due to (or as a consequence of): Multiple mysloma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off, Hyperstensivn

Due to (or as a consequence of): Hyperlinidemia Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Day Year 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

/Medical Examiner Records, P.O. Box 68760 or Vital Division the Hospital or Attending hin 24 hours after death. within 24 hours after death To the Funeral Director:

the Maryland

3altimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jayant

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

tirrara

DHMH 17 Rev 1/2001

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dsley

29c. License number

D5274

DYING

TOWSUN

29d. Date signed (Month, Day, Year)

08-05-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Month Physician/ James Ρ. Farrell w Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) Aug. 05 1938 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months 1 🗓 M 2 🗆 F Hours Director 212-36-7402 71 Yrs. Aug. Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral filed within 72 hours after death with 832 Barbara Court 21060 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Anne Arundel County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked ot jury or other traumatic ever ၉ Frank Farrel1 Rose Granahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Patricia Farrell 832 Barbara Court, Glen Burnie, MD 21060 (spouse) Baltímore, Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. 07 20c. Location - City or Town, State permit. Page 1 a
Department of H 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Haven Cemetery **2010** Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused to e death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on ach live. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical nsequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invertal director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ ER/Outpatient 3 DOA 1 Inpatient 2 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗀 No Investigation 6 Could not be *Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and some states of the state of the basis of examination and some states.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010

State Registrar 31. Date filed (Month, Day, Year)

Burnie, mo

30. Name and addless of person who completed cause of death (tem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtI, II, 25 per me, g906,08/06/2010dnb

Certificate of Death

Reg, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FREDRICK, JR. Physician/ WILLIAM Month Day 20 Year 1642M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 □ F Months Days Hours Min Apr. 13, Year 1939 71 Director 217-34-6449 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Sykesville MD Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6731 White Rock Road 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 n and Mental Hygiene. 7 is marked other than "I (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Sales/Parts Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ex 2 William E. Frederick, Sr. Verna Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ruby T. Frederick (Wife) 6731 White Rock Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Lorraine Park Cemetery 7/6/2010 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses M00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate neumonia Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of), Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of LEXAMINER CERTIFICATE WAFROVED BLANCURAL Chronic Obstructive Pulmonary Disease Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Thorocotoine 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ma wheether, due to Chronic 24a. Was an er this certificate has performed? Yes 2 No Obstructive Pulmonary Disease 1 Yes 2 No 25. Was case referred to medical examiner?

1 X Yes 2 🖽 No Be 26. Place of Death (Check only one) Hospital 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled Medica 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

(g)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month.

447,

man

Hosain MD

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

AUG 0 6 2010

39502 MD

7/2/10

East Main St. Westminster MAZUTT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear 2:01 4M **Physician** 2010 amesHa ugh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Manor Care Ruxton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1 🛛 M 2 🗆 F 79 02/12/1931 U.K. Director 578-54-6481 Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10a State ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Baltimore N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United Kingdom 21213 2316 Erdman Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 🛛 No Specify: White Completed by 3 Widowed 4 X Divorced "natural" 16b. Kind of Business/Industry 16a Decedent's Usual Occupation event, the Modical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) A 27 is marked other than "n r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Pest Control Exterminator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rutherford Margaret Forbes ၉ Reginald Arthur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 2316 Erdman Avenue,,Baltimore, MD 21213 Pages 1 and 2 Peter J. Forbes, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/09/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hillton Svc. Corp. 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Eleponaus o Baltimore, MD 21214 5305 Harford Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days Dementio **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tra Due to (or as a consequence of) P.O. Box 68760 Physician/Medical the attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 ☐ Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 70 V autopsy performe has page 2 certificate I 1∏Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient After this Certification: To 28d. Describe how injury occurred Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

3

State Registrar Lane #216, Towson, Maryland 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>10</u> Physician/ 11:20 AM Angelica R. Franquelli August 4 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson . Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth

July 19,1942 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 🗆 M 2 🕱 F Days 328-42-1070 68 Phillipines Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State e filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director be notified N/A Maryland Baltimore 1 X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 524 N. Charles Street Apt 1016 21201 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc ö by 1 X Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify. the Med cal 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Proffessional Pianist + Music Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ Aquiles Ρ. Montinola Consuelo Franquelli Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau 251 Chantrey Rd. Wilhelmina Paglinauan - Friend Timonium, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entanbment 8/7/2010 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 Han 5305 Harford Rd. Ruck Inc. Leonard J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 19 months?

1 Yes 2 No Dav Year Pregnant at time of death within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 ☐ Unknown No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Menner of Death 28b. Time of 28c. Injury at 28d. Describe how injury 5 Pending work? 1 🔲 Yes Natural 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 only one) critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signatu

and title of certifier

31. Date filed (Month, Day, Year) 🐷 32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)



icense number

Date signed (Month, Day, Year)

1204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 2461 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Colleen M. Grimes 1:30 PM 08/02/2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1599 Shannon O Circle Severn Social Security Numbe If Under 1 Year Date of Birth Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Birtnpiec Country) MD Days 1 🗆 M 2 🔀 F Months Hours Min. 213-34-0088 07/24/1936 74 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Direct 1 Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral States 1599 Shannon O Circle 21144 United 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 | h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Store Clerk Retail Convenience Stor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Sadler Margaret Yinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Floute Number, City or Town, State, Zip Code) and 2 sh Health a 1599 Shannon O Circle Severn MD 21144 Son Arron Grimes If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GUST 4 Donation 5 ☐ Other (Specify) Uniformed Services 2010 Bethesda, MD 21. Signature of Funeral Service treasee Mo0382 22. Name and Address of Facility

Rapp Funeral & Cremation Service.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 933 Gist Ave.20910 Rapp Funeral & Cremation Ser. Silver Spring MD Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Disseminat Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Caquaintially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami certificate be execute Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Vear Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 N certificate 2 XNo 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending s after dea... al Director, After injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar only one)

29b. Signature and title of certifier

Maemella 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Physician

32. Registrar's Signature

Aggielm

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

cause of death (Item 23a) (Type Print)

Malison Paule Dure #16 Oten Brownie IMD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2010 Regina Stella Gasiorowski 8:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 44 Benoni Circle Middle River If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug | 8, 1942 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎗 F Maryland Director 219-40-0100 67 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Baltimore Middle River Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21220 44 Benoni Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: White 3 ☐ Widowed 4 🎇 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) q Care Giver Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edward Palasik Stella Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benoni Circle Middle River, Maryland 21220 <u>Richard M. Gasiorowski,</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 08/04/10 Baltimore, Maryland Signature of Funeral Service Licensee remation Society Of Maryland, Inc. 99 Frederick Road Baltimore, Maryland Thomas Gregor 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ STAGE CARDIAL DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death a \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available 24a. Was an After this certificate has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d, Date signed (Month, Day, Year) D57722 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 GREENE TREE ROAD # 300 PIKESVILLE MP 21208 CETHAD RICHADISON 32. Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

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Baltimore, permit. Page 1 and Department of Hea	Important: If any injury or once,	ı J	21. Signature of Funeral Service Licensee			Name and Addressing Homeseverly L.						21029
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State		01-0		31. Date filed (Month Day Year)	Hers	Signatura	J-1	utily 1	LUAL		71/12/	11 12 12	' > / !	SUPPLY
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:05 A M LYUBOV **GABAY** Jugust 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ta Baltimor ltimore N/A 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖵 F Months Hours Min 0872071924 **BELARUS** 85 Director 214-43-6531 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A BALTIMORE MD npor 10e. Street and Number 10f. Zip Code 10g.·Citizen of What Country? Funeral 3601 FORDS LANE, APT. 410 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) FOOD STORE MANAGER Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FUNDILLER GABAY RONYA MIKHAIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 MOORES VALLEY DRIVE, BALTIMORE, MD MARINA BOGIN/GRANDDAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burlal 2 Cremation 3 Removal from State cemetery, crematory or other place) BALTIMORE HEBREW CEM : 08/05/2010 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 21 density of Fundament ervice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ER/Outpatient 3 DOA 잍 1 Inpatient 2 eral Director: After this filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie ddress of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore Justin MD Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Gabay

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar Certificate of Death Reg. No.	2401
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death
Medical Examiner	RONALD LEE HAMM August 3, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	2039 hrs
	5220 York Road Baltomore	
Funeral Director		hplace (State or MARYIAND untry)
any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Aaryland 28a-f show Latonce. ector	MD BALTIMORE	1 Yes 2 No
e Mary or 28a- ied at	10e. Street and Number 10f. Zip Code 10g. Citizen of What Coun	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	5220 VORK KOAD 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
death or item must b	1 Never Married 2 Married Armed Forces? 1 Yes 2 No White, etc.	
ural", miner	3 Vidowed 4 Divorced in tes, Give rear or Dates: 1 Yes 2 HNo specify: Spec	
, MD 21215-0036 and 2 should be filed within 72 hours after feath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner To Be Completed by 1	during most of working life, DO NOT use retired)	
5-0036 led within 7 tygiene. other than the Medica	Elementary/Secondary (0-12) College (1-4 or 5+) Correction A OFFICER LAW ENFO. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)	ACE MONT
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. item 27 is marked other than r traumatic event, the Medica To Be Comple	LEON HAMM ROSE TRAYHAM	
2121; hould be fil and Mental H is marked itic event,	19a. Informant's Name/Relationship (Type, Print,) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,	Zip Code) 2/2/7
e, MD and 2 sho lealth and item 27 is traumati	LEONARD HAMM BROTHER 2018 MADISON AVE. BALTIMORE, MA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location City or T	Fown State
nore ages 1 a nt of H it: If it	1 Burial 2 Cremation 3 Removal from State crematory or other place)	= landulans
Baltimore, permit. Pages I an Department of He. Important: If ite	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21 Signature of Funeral Service Lio see 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY INC. 22. Name and Address of Facility ERRICK C. Jon	JES. F/H.P.
	TOTT PARK HOTS. AVE. BALTIMORE	MAX 121213
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. ATTEFOSCIEFOTIC CARGIOVASCUIAR DISEASE Due to (or as a consequence of):	,
<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
red Insit	cause. Enter Underlying Cause (Disease or injury that initiated	
cecuted and transit		
'60, rate be execu physician an ne burial - tr	UNPENDED AMENDED	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The law requires that the death can be seen signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - trans direal Certification: To Be Completed by Physician/Medical E	23b. Was decedent pregnant in the 1 Live birth a Fotal death 3 Ectopic pregnancy Month Di	ay Year
Box 687 e death certific the attending r ed for use as th	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	,
P.O. Bc that the december by the additional detached for by Physical By Physical detached for by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the conditions conditions.	he cause of death?
res that the signed by be detack	Chronic alcohol abuse 1 Yes 2 No 3 Proba	abiy 4 🗹 Unknown
Division of Vital Records, Ital or Attending Physician: The law requires rs after death. The Director: After this certificate has been signed in by the funeral director, page 2 should be extification: To Be Completed	24a. Was an 24b. Were autopsy prior to co	opsy findings available ompletion of cause of
tal Recorian: The la certificate ha ector, page 2	performed? death? 1 Yes 2 No 1 Yes	s 2 No
ital sician: s certif irector,	25. Was case referred to medical examiner? Hospital:	Scene
Division of Vital Ispital or Attending Physician: ours after death. Theral Director: After this certification by the funeral director. Certification: To Be C	27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	000110
sion ttendii death. ctor: A y the fu	1 Yes 2 No No No No No No No	
Division o spital or Attending hours after death. neral Director: Aft y filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2Bf. Location (Street and Number or Rura or Town, State)	al Route Number, City
the Hospital hin 24 hours the Funeral npletely fille	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only).	
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	
Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month 29d. Date signed (Month	in, Day, Year)
	30. Name and a down of person who completed cause of death (Item 23a)	
_\V	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	<u> </u>
State Registrar	4 11 0 0 7 0 0 0 1 0 1 1 1 1 1 1 1 1 1 1	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2050 PM Month Physician/ William Hartjen Рм Christopher 8:50 August 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Monkton 619 E.Pinev Hill Rd. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours July 02, 1982 1 🕅 M 2 🗆 F 28 North Carolina Director 213-17-0185 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Baltimore Md. Monkton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 140/80 na Funeral 619 E. Pinev Hill Rd. 21111 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 X Never Married 2 Married Yes 2 No 21215-0036 White 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Remodel Supervisor Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked Donna Ruff Charles Α. Hartjen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 E. Piney Hill Rd. Monkton, Md. 21111 Mr. Charles A. Hartjen/ Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of 1 X Burial 2 Cremation 3 Removal from State 8-9-10 Lake View Mem. Park Sykesville, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Addre Ruck Cility owson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical 111. Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician Physician/Medical the use as IF FFMALE 23b. Was decedent pregnant 23d. Date of delivery forι in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year as been signed by the 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No page death? or Attending Physician; The certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Se(28c. Injury at Certificate: work? 1 ☐ Yes 2 WNo 5 Pending 1 Natural inflicted August 1 2010 2650 P M 1 28 Place o Injury - At home, farm, street, factory, office building, etc. (Specify) Accident Investigation unshot wound the 24 hours after deat Funeral Director; 3 Suicide 4 Homicide 28f. Location (Street) and Number or Rural Route Number, City or Town, State) 6.9 FPInehill Road 6 Could not be completed filled in by determined 10 mp Monkton Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certific 9c. License number eath (Item 23a) (Type, Print) completed cause of 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Patricia Head Barbara JULY 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES TIMOR Birthplace (State or Foreign Country)
 MD If Under 1 Yea If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 05–08–1940 Social Security Number Age (In yrs. last birthday **Funeral** Months Hours Days 1 □ M 2**x**xF Min. Director 212-36-5252 70 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items ??? any injury or other traumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6217 Parkview Court 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 24 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Completed by 3XXWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Mortgage Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Galvin Kuhn Thelma Emma Kuester ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite K. James - Sister 6217 Parkview Court, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem Prk. 07-31-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licenses MMP., Inc., 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SCHEMIC CARDIO MY OPATT YEARS /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence off: Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 4. Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 ☐ Yes 2 Ø No HEAD, B. Bivision of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: I in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN BATIMORE KONBUILLO CATUN 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

BARA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 22 per fh g906 8-6-10 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Lucille G. Halkias 6:32A August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MD 1 M 2 X Months Days Hours Min 12-11-1931 78 Director 213-28-6907 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10d Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7065 Eastbrook Ave. 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or item edical Examiner ת 11. Marital Status 14. Race - American Indian Armed Forces Black White etc. ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Completed 3 XWidowed 4 ☐ Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N 12 Traffic <u>Manager</u> Anchor Fence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Anthony V. Vece Mary E. Zeronski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delvale Ave., Dundalk, Beverly Xintas - Niece 1409 ΜD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, 8-9-10 Orthodox Signature of Funeral Service License Funeral 22. Name and Address of Facility Bradley-Ashton Home Spring Road <u>2134 Willow</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small Bowel Physician/ Obstruction disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of). Cause (Disease or linjury that initiated events executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Vear Pregnant at time of death
Unknown 2 should be detached signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by artic anemy sm 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an History a cancer After this certificate has autonsy page ☐ Yes 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director: A Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of a variation and/or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the cause of a variation and or inventioning in the caus Medical 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)067063 815 30 Marne and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, and 21204 Patel 4701 N Charles St MD in 31. Date filed (Month, Day, Year) 32. Re strar s Signature State Registrar

			For State Registrar	State of	f Maryland / Dep <i>Ce</i>	artment of I	Health and M <i>Death</i>		ien 2 0 0	24622
	Physici	an	Decedent's Name (First, Middle MARGARET)	le, Last) NEILL HOLME	S			2. Date of Death	3, Day 2010 Year	3. Time of Death 11:20 A M
-	/Medio		4a. Facility Name (If not institution			4b. City, Town, o	or Location of Death	7100001	4c. County of Death	
-		٠.	Nichols S	helter Ass	isted Living	Edgew	700d		Harford	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		217-20-4644 Usual Residence of Decedent	,	92 Yrs.			Nov. 28	, 1917 Ala	bama
	yland Now		10a. State 10b. County	•	10c. City, Town or L	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland Har	ford	Belcamp					1 □Yes 2⊠ No
	or 28	Dìre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	intry?
	s 23a	eral	1208 Mistwood	Apt. 301		21017			USA	
	after death with the Marylan or items 23a or 28a-f show mitter must be notified at	Funeral Director	11. Marital Status1 ☐ Never Married 2 ☐ Mar	Armed For	dent Ever in U.S. rces? 2 X No	If Yes, specify Cub	Hispanic Origin? (Spe oan, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Amer Black, White	
036	hours after death with the Maryland tural", or items 23a or 28a-f show at Exantinest ba rotified at	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv	/e	1□Yes 2⊠No	Specify:		Specify: Whi	te
5-0	72 hours "natural",	eted	15. Deceder	nt's Education est grade completed)	16a. Dec	edent's Usual Occu	pation during most of working	na i	16b. Kind of Business/I	19.19
121	vithin ine. han "	Completed by	Elementary/Secondary (0-12)	College (1	-4or 5+)		during most of workingd)		Chata Car	
d 2	filed v Hygie other 1	CO e	8 17. Father's Name (First, Middle,	Last)	Acc	ountant_	18. Mother's Name	(First, Middle, N	State Gov	erment
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, it s. Ms	To Be	Roy (unk) Long	,			Martha	(unk) Pe	eterson	
ary	shou and N s mar		19a. Informant's Name/Relations	ship (Type. Print)	19b. Mail	ing Address (Stree	1		; City or Town, State, Z	ip Code)
	and 2 ealth n 27 l		Mary A. Becker	/ Dayighte:			Drive, Be			
ore	Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natuu Iny or other traumatic event, It a Mexical		20a. Method of Disposition 1 ☑ Burial 2 □ Drémation	3 🗆 Removal from S	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	nce) D	ate	20c. Location - City or I	own, State
Baltimore,	t. Pa rtmen rtant;		4 □ Denation # □ Other (5	Specify)	Lakeview				ykesville,	Maryland
Bal	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau		21. Signature of Full-ral Service	MIL	ا ملک	L317 Coke		, Abing	don, MD 210	009
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that ca t only one cause on ea	aused the death. Do not each line.	nter the mode of dy	ing, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. A/Z	heimer 's or as a consequence of):	type	Dementi	'a		Onset and Death
4	/Medical Examiner									
	1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due/to	per tension or as a consequence of):	010				
	ecuted nd transit	Examiner	that initiated events	c. Hy	per choles	terolen	nia			
8760,	law requires that the death certificate be executed as seen signed by the attending physician and 2 should be detached for use as the burial-transit	Ξ	resulting in death) Last	Du ę /to/(or as a consequence of):					
87	physi physi the b	dical		d						
Box 6	leath certifica attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy				23d. Date of deli	verv
Ä	death e atte	iciai	in the past 12 months? 1 □ Yes 2 No	4 ☐ Pregr	nant at time of death 5	☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	cy		Month	Day Year
P.0	that the de ned by the a detached f	hys	9 Unknown	9 □ Unkno						
S,	res th	by	Part II. Other significant conditi	ons contributing to de	eath but not resulting in the	underlying cause gi	ven in Part I.		oacco use contribute to es 2 ⊠No 3 □ Pr	the cause of death?
Vital Records,	w requir	Completed	-		 			1 □ Y€		
Rec	The law ate has page 2 t	mp						24a. Was a autops perforr	y prior to d	topsy findings available ompletion of cause of
ta	ysician: The lavis certificate has director, page 2.3		25. Was case referred to medica	1			26. Place of Death		2 X No 1 ☐ Yes	2 □ No
Ž	ysici lis cer direct	o Be	examiner? 1□ Yes 2 No	Hospital:	npatient 2 ER/Outpatio	ent 3 DOA Ot	her: 4 \sum Nursing Hon			Assisted
n of	ding Phys h. After this funeral dii	L:uo	27. Manner of Death 1 Natural 5 □ Pendir	28a. Date o	of Injury 28b. Time Injury	Wo			ow injury occurred	Living
Sio		cati	2 ☐ Accident investi	not be	of Injury - At home, farm, s		Yes 2□No	106 L 100		10.74
Division	II or Attend after death Director: / d in by the f	Certification: To	4 ☐ Homicide determ	nined 20e. Place buildir	ng, etc. (Specify)	reet, factory, office	2	City or Town	reet and Number or Ru n, State)	rai Houte Number,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C			best of my knowledge, dea asis of examination and/or in her stated.					
	To the vithin To the comp	Me	29b. Signature and title of certifie	er - 1		29c. Licen	se number	2	9d. Date signed (Month	i, Day, Year)
			Stephen	nce Ir	e of death (Item 23a) (Type	00	045909	1	Jugust "	1,2010
			30. Name and address of person	who completed cause	e of death (Item 23a) (Type	Print)	Janna n	10 21	085	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland				Hygier	ne	
			State Registrar		Cer	tificate of Deatl		Reg.	No. 2010	24523
	Physicia Medic		Decedent's Name (First, Middle, Last)	Ernest Ash	ton H	ancock, Sr.	2. Date o Month Aug.		Day Year 2 2010	3. Time of Death 1:50 A M
	Examin	er	4a. Facility Name (if not institution, give str			4b. City, Town, or Location			4c. County of Death	
-			Stella Maris Hosp 5. Social Security Number 6. Sex	pice Center 7. Age (In yrs. last	hirthday)	Timoniu		f Rirth	Baltimore	Place (State or Foreign
	Funeral Director			M 2 □ F 85	Yrs.	Months Days Hour	s Min. (Month	, Day, Year	r) 1925 Vii	
	- Mo →	,	Usual Residence of Decedent					- / . 1		
	ırylanı I-f sh ied a	Director		imore loc. City, i	Town or Loc	Edgeme	re			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ne Ma or 28¢	Dire	10e. Street and Number			10f. Zip Code		10a.	Citizen of What Cour	
	with t	Funeral	3105 Greenhill Ro	oad		2121	9	1 -	nited Stat	
	Jeath items ier mu	Fun	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mexi-			14. Race - Americ	can Indian,
36	after o	l by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give	- 1	Yes 2X No Spec			Black, White, Specify:	
8	nours atura cal E	Completed	15. Decedent's Educ	Year or Dates. WWII	16a. Deced	ent's Usual Occupation		16h	. Kind of Business In	White
215	n 72 h e. aan "n Medi	du	(Specify only highest grade		(Give k	ind of work done during m O NOT use retired)	ost of working		. Kind of Eddiness in	dustry
7	l withi /giene ner th t, the		12 Years	l Year	Eng	ineer			Steel Indu	ıstry
and	e filed ntal Hy ed otl	To Be	17. Father's Name (First, Middle, Last)			18. Mo	other's Name (First, Mic	ldle, Maide	en Surname)	
ڇ	ould bird Mel		Herbert Hancocl 19a. Informant's Name/Relationship (Type	T	40b M-10-	g Address (Street and Nur	Effie Lam	mbar City	or Town State Zin	Codol
\mathbf{Z}	12 shulth ar alth ar 27 is rtrau		Mrs. Beverly A. Bo			05 Greenhill				
re,	1 and of Hez item		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of natory or other place)	Date	20c.	. Location - City or To	own, State
<u><u>Ë</u></u>	Page ment ant: It		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		ens o	f Faith Cem.			Rosedale,	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licepeee	Red	²² D	Name and Address of Fa uda-Ruck Fur 1922 Wise Av	olity 1eral Home 1e. Dundall	of Du	undalk, Ir 21222	nc.
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one		Approximate Interval Between					
F	hysician,		Immediate Cause (Final disease or condition	CEREBROVASCU	LAR A	CCIDENT				Onset and Death
· And	Medical Examiner		resulting in death)	Due to (or as a consequen						_
		ier	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequen	ića ofi.					
	rted J nnsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury							
9.	execu an and rial-tra	EX	that initiated events c. resulting in death) Last	Due to (or as a consequen	ce of):					
09	ate be executed hysician and the burial-transit	dical	d.							
687	ertifice ding p	/Me	IF FEMALE:	c. If yes, outcome of pregnancy	v					
ŏ	attende for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal d 4 Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)		_	23d. Date of deliv Month	ery Day Year
	tne de sy the ached	hysi	9 Unknown	9 🗆 Unknown						
<u>.</u>	s that gned b	by P	Part II. Other significant conditions cont	ributing to death but not resulti	ing in the u	nderlying cause given in Pa	art I. 23e. [id tobacco	o use contribute to the	ne cause of death?
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OS:	law re nas be e 2 sh	Completed					a	Vas an utopsy	prior to co	psy findings available impletion of cause of
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of o	g Pny erthis neral c		27. Manner of Death		Bb. Time of injury	28c. Injury at			jury occurred	HOST ICE
ou ·	endin sath. or: Aft he fur	fical	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Mornin, Day, Year)	II IJUI Y	work? M 1 ☐ Yes 2	□ No			
Division of Vital Records, P.O. Box 687	ial or Attendir s after death. al Director: Af ed in by the fu	l Certificate:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		on (Street a Town, Sta	and Number or Rura ate)	l Route Number,
- :	The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hourst after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examine	ian: To the best of my knowled r: On the basis of examination ar Practioner: To the best of my kr	nd/or investi	gation, in my opinion, death	occurred at the time, d	ate and pla	ace, and due to the ca	use(s) and manner stated.
	Northi Comp	-	29b. Signature and title of certifier	OD CANP		29c. License number			Date signed (Month,	Day, Year)
	wil			npleted cause of death (Item 23			MONTHS: 17	01000	- (
	Stat	e	JACKIE JONES, CRN	P 2300 DULANE 32. Registrar's Signature		LEY KD. TIM	ONIUM, MD	<u> 21093</u>	5	
	Registra		AUG 0 6 20	10	1	hadel				
	■ 17 Pov 7/00		400	455	- /					

AUGUST 2, 2010 1:50 a.m.

ERNEST HANCOCK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anna C. Hyman 10:51AM August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2🗶 F Days Hours Min. (Month, Day, Ye Feb. 14, Maryland Director 93 1917 <u>214-01-0636</u> ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pines. 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 🗆 Yes 🏞 No Harford Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 U.S.A. 2211 Ringing Fox Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Bar Maid 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelina D'Italia Vincent Coleianne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211Ringing Fox Court, Bel Air, Maryland21015 Diane M. Dietz/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 8-7-10 4 Donation 5 Other (Specify) MostHolyRedeemer 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P. A michael <u>6009Harford Road,Baltim</u>ore,Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician cordianyona Ischemic disease or condition ver (Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury transit. or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last use as the burialattending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 9 Unknown should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital 2 No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Hospital Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination arrow investigation, it my opinion, seal records as the land blace, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature d title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANKS Ni M. 6701

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. U Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Ye a **Physician** 4UGUST $\mathcal{N}\mathcal{N}\mathcal{A}$ /Medical or Location of Death 4a. Facility Name (If not institution, give street and number) 4c ounty of Death 4b. City, Town, Examiner 4einsel RNOL recar If Under 24 Hrs. If Under 1 Year 8. Date of Birth Mar 12, 1926 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday, **Funeral** 1 □ M 2 □ F Days Months Min. Germany 249-52-7026 84 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exercity of the notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Glen Burnie Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 U.S.A. 609 Tanyard Cove Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 1 If Yes, Give Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 beatment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event." 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Stephan Dora Stephan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk Avenue Baltimore, Md. 21222 1708 Dora Wickline-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ugust 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State |Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bayview Crematory: 21. Signature of Funeral Service Licensee 22. Name and Address of Facilities Raczorowski Funeral Home, P.A. 1201 Dundalk Avenue Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** OYDAR CONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or se's consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a □Yes 2 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 □ No 3 □ Probably 4 □ Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No this certificate 2 1 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the Director; 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

2

and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan		rtment <i>tificate</i>			and M		21	010	24626
			Registrar 1. Decedent's Name (First, Middle, La	ast)		001	imouto		-		2. Date of Dea	Reg. Né		3. Time of Death
	Physicia		PHILIP			-	HOLZM	A INT			Month AUGUS'	Day	2010 2010	12:30A M
	Medic Examin		4a. Facility Name (if not institution, giv	re street and number	er)		4b. City, To		ocation o	f Death	HOGOD		nty of Deat	
	t Examin		SEASONS HOSPICE @			рттλτ	,		LSTOW				LTIMO	
	Funeral				Age (In yrs. la		If Under 1		If Under 2		8. Date of Birt	th		
	Director		215-14-9670	Sex. 7. 1 ☑ M 2 ☐ F	3 ()	88 Yrs.	Months	Days	Hours	Min.	(Month, Da 04/02)	7 1922	Co	thplace (State or Foreign untry) MD
			Usual Residence of Decedent								<u> </u>			
	and sho	ō	10a. State 10b. County		10c. City	y, Town or Loc	ation							10d. Inside City Limits
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	or 2	₫	10e. Street and Number		•	_	10f. Zip (Code				10g. Citizen of What Country?		
	with 23aust bust b	era	6 BROADRIDGE LAN	ΙE			2	1093				USA		
	eath tems er m	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.S	3. 13. V	Vas Decede Yes, specif	ent of His	panic Orig	gin? (Spec	cify Yes or No-			rican Indian,
9	ter d , or i	ğ	1 Never Married 2 X Married		No No					, ruerto r	nican, etc.)		Black, White	e, etc.
ຊິ	e filed within 72 hours after death with the Maryland tal Hyglene. An experience of the than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	3 Widowed 4 Divorced	If Yes, Give Year or Date	S.	1 L Yes 2 △ No Specify:					Spec	WH.	ITE	
21215-0036	2 hou	ble	15. Decedent's (Specify only highest g			16a. Deced	and of work	done du		of workir	ng	16b. Kind o	f Business	Industry
2	hin 7 ne. than	E O	Elementary/Seconday (0-12)	College (1-4	or 5+)		O NOT use i	,	DD117	200		0.7.00	O.II	nat milionii
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Maryland	be filed within 72 hours after death with the Maryland red all Hyglene. Rend Hyglene when the state than "natural", or items 23a or 28a-f sho ker deter than "natural", or items 23a or 28a-f sho ite event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last)	•		IIOT 6344	A.T				(First, Middle,	iviaiden Surri		CERTN
ž	12 should be file lith and Mental 27 is marked o r traumatic eve		SAMUEL	HOLZMAI T	IAN ANNA ailing Address (Street and Number or Rural Route Nur				BERNSTEIN					
<u>8</u>	2 should Ith and Me 27 is marl		19a. Informant's Name/Relationship (3 ,							·
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٥			1 🛭 Burial 2 🗆 Cremation 3		ate c	emetery, crem	natory or oth	her place					•	
Baltimore,	t. Par tmer rtant rjury		4 Donation 5 Other (Spec		BA	LTIMOR		_			5/2010			TOWN, MD
g	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	iseen III.							LEVINS			
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م	Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	10 E.S.							
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	and trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or	as a consequ	ience off:						·		
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200	artific ding page as	Ĭ.	IF FEMALE:	23c. If yes, outco	me of pregna	ncv							D 1	
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ň	e dea the a	Physician/Me	1 Yes 2 No 9 Unknown	9 Unknov		Jean 5L	other (spe							
o	at th d by detac	h.	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying ca	ause give	n in Part I	i.	23e. Did to	obacco use c	ontribute to	the cause of death?
ν. J.	res the signed be controlled	d by									1 🗆	Yes 2 □ N	lo 3 □ P	robably 4 Unknown
ğ	een	ete					•				24a. Was	an 2/	1b Were au	rtopsy findings available
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<u>ra</u>	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Other	ce of Deat				Mpat	rent finences
>	Phys this al dir	2	1 Yes 2 No 27. Manner of Death	1 In		ER/Outpatier 28b. Time of		A Injury	4 ⊔ Nu		me 5 🗌 Resid 28d. Describe l			(ity) 4 to year
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000	deat deat ctor: / the	Certificate:	2 ☐ Accident Investigation in the street of	be 280 Place of	Injury - At ho	ome, farm, stre				\rightarrow	28f Location (5	Street and Nu	mber or Ru	ral Route Number,
Division of	after after Dire	S	4 Homicide determined	building	, etc. (Specify)	, ,				City or Tov			, , , , , , , , , , , , , , , , , , , ,
_	spita iours ieral	cal	29a, Certifier 1 Certifying Ph	ysician: To the bes	t of my know	ledge, death o	occured at the	he time,	date and p	place, and	d due to the ca	use(s) and ma	anner as sta	ated.
	e Ho 1 24 h e Fur	Medical	(Check 2 Medical Exar		of examination	n and/or invest	igation, in m	ny opinion	n, death oc	curred at	the time, date a	and place, and	due to the	cause(s) and manner stated.
	To the Hospital or Attending Physician: The law lequires that the death certifica within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has it een signed by the attending pocompleted filled in by the funeral director, page 2 should be detached for use as to completed filled in by the funeral director, page 2 should be detached for use as to complete the filled in by the funeral director.	-	29b. Signature and title of certifier					License				29d. Date sig		
			Allo Ma	nath			D	004	337	25		08/0	4/71	5/70
			30. Name and address of person who	completed cause	of death (Item	23a) (Type, F	rint)	7	•		1	- 1/-	1.	
)				Note 2	835 8	SMITH	- AVE	5 2	VITE	720	3 24	THON	8,M	21209
	Sta	е	31. Date filed (Month, Day, Year)		istrar's Signa	ture	1	A						
	Registra	ar	AUG 0 6	2010 🔏	of the second second	1. A	ack							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2:40 PM Birthe Helene Johnson 04 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hespital Baltinore . Ac N/A nes 8. Date of Birth July 23, 1930 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 80 195-44-1510 Denmark Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydron Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 719 Maiden Choice Lane Apt HV 613 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ♥ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk.Schwartz 2 Paul Andersen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 242 West Davisburg Road Holly, MI 48442 Karen Johnson, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 08/05/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 22 Name and Address of Facility Of Maryland, Inc. Thomas 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death 3 days Immediate Cause (Final Hepatic Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Sequentially list conditions, if any, leading to final educations. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an performed 1∐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P- 24064 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year,

21229

Caton Avenue

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MILTON KOPP Day RONALD **Physician** 4:30 PM 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rosedale timore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 2-12-1938 9. Birthplace (State or Foreign **Funeral** yrs. last 219-26-6469 1 M 2 □ F MARYLAND Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at BALTIMORE ROSEDALE 1 ☐ Yes 2 ☐ XNo Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 1117 ROSEDALE AVENUE 21237 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or ite other traumatic event, I' a Modical Examina. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 □Yes 2 🛣 No Specify. Specify: Completed by WHITE 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-0 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE COUNTY Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS CHEIF CUSTODIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILTON KOPP HELEN (HERTEL) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA A. KOPP/WIFE 1117 ROSEDALE AVENUE ROSEDALE, MD 21237 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State CATONSVILLE, MD METRO CREMATORY 8-9-2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Exami and the burial-trar Due to (or as a consequence of) physician Physician/Medical as attending use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy fort in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate 1 □Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2√ No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after deatl To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal completely (Check only one and manner stated. 29b. Signature and title of/certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

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Courtenay

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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-4-2010

DR Balto Md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24629 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SANG 2300 AUG 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Howard County General Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min S. Korea 0276271920 Director 216-92-4617 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21044 10231 Dottys Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 AANo Specify. 3 ★ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Board of Education Superintendent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sun Nam Kim Ki Yong Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21044 10231 Dottys Way Hong Jin Kim 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Meadowridge Memorial Park 8/4/10 Elkrige, Maryland 4 Dominion 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, I 7250 Washington Blvd., Elkridge, MD 21 form. 23a. Part 1. Enter the disease, or complications that caus shock, or lyeart failure. List only one cause on each immediate Cause (Final Shock Onset and Death Card (ogenic Physician/ disease or condition Medical resulting in death) **Examiner** Cardiomyopothu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner attending physician and for use as the burial-transit atheroscieratic Cardiovascular dijease The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cancer Esophasea/ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a, Was an performed Hyperfension 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) DO043662 Aug 1,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOYCE Howard Co. General WILLAM 31. Date filed (Month, Day, Year)_ State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Richard Thomas Kearns 12:15 P M August 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9530 Perry Hall Blvd. Apt.101 Baltimore Perry Hall 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F 214-36-7965 Director Marylam 1938 Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ient, the Medical Examiner must be notifiad at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items ?? any injury or other traumatic event, the Maryland once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Perry Hall 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 9530 Perry Hall Blvd. Apt. 101 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry United States Army Elementary/Seconday (0-12) College (1-4 or 5+) Medical Specialist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Blanche Lafferty Hunt Leonard Thomas Kearns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzette Jeng/ Niece 215 Rachel Circle Forest Hil, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Vans Funeral

Janel - Bel Air 1 Burial 2 K Cremation 3 Removal from State Forest Hill, MD vans 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Evans Funeral 8800 Harford . Signature of Funeral Service Licenses Chapel & Cremation Rd. Parkville, MD 2 Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final rectal Physician/ cancer dise se or condition realting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 No Yes 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ျ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending iniury 2 Accident
3 Suicide Investigation 1 Yes 2 No Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours

State Registrar

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Medical

29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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es of person who completed cause of death (Item 23a) (Type, Print)

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X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Franklin

August 5, 2010

Syuma DrieBaltimo MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 August 3:30 P M Mary Catherine Kidd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) Aug. 12, 1922 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex Funeral 1 □ M 2 🔀 F Maryland Director 217-22-5775 87 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tem 27 is marked other than "natural", or trems 23a or 28a-f show any injury or other traumatic event. the Medical Examination. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1469 Landis Circle 21015 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ 1 Yes Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary (unk) Diddlemyer Edward (unk) Drumgoole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Blevins / Daxighter 1469 Landis Circle, Bel Air. MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Byrial 2 🖟 Cremation 3 🗆 Ren om State Otber (Specify) 8-7-10 bnation / Baltimore, Maryland of Faith Cem. ²² Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SEPSIS Physician/ FRAM NEGATIVE disease or condition Medical resulting in death) Examiner PXELOWEPHRITIS ACOUTE Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury DESTRUTIVE NEPHOLOGATHY. the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical PELVIC MA-85 Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown a I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by EMPHYSEMA ivision of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an or Attending Physician: The law autopsy performed? Yes 2 ACNO has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: 2 🔀 No 1 Impatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioners To the best of my knowledge. D08096 AUGUST 3, len Nons 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FULFORD ME: BELAIR, MD 2/0/4 NOWAKOWSKI MOREW 35

DHMH 17 Rev 7/2009

State Registrar

OR

31. Date filed (Month, Day, Year)

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ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24632 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Catherine Keefer 2010 11:06 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Stella Maris</u> Timonium Baltimore 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Days Hours CountMaryland **Director** 215**-**09-9468 94 10-02-1915 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll Manchester 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Lynn Ridge Court 21102 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Kurgan Maryanna Krawczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas Keefer - Son 13 Lynn Ridge Court Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 08-09-2010 Baltimore, Maryland 21. Signatule neral Service Ligenses 22. Name and Address of Facility 5305 Harford Road rale Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Physician, Onset and Death disease or condition resulting in death) neumoni Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease of injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has 24a. Was an autopsy performed? Yes 2 Day 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ernestine Wright, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM 21093 MD31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Dav Vear Physician 7:55 A M 04 Kosiorek 08 Antoinette 010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Manor Care - Ridge Road Rosedale Baltimore Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 – 1 7 – 1 9 2 7 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 🛣 F 83 Maryland 217-22-0188 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ∏Yes 2 KINo Director MD Baltimore Co. Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 7332 Manchester Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: White 3 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) Western Electric Secretary is marked other 18. Mother's Name (First, Middle, Maiden Surname) (unk) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Health and Mental Edward Balakier Teofilia ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau 7332 Manchester Rd. Dundalk, MD 21222 Anita Michalak-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8 - 7 = 20101 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Cem. Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, 1 1201 Dundalk Avenue Baltimore, MD 21222 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Landishul **Physician** /Medical Due to (or as a consequent e of): heart disease Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 D Ectopic pregnancy for Month Dav Year 5 ☐ Other (specify) ed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69540 M.D 2010

State Registrar

Tay of

68760

Box

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Suite

204 larkville MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ouds Rd

Please Type or Print in Black Indelible Ink Figure All Conies Are Legible

lobert Lee Loc	kett	State of Maryland / Department o 1- For State Certificate of	f Health and Mental H	ygiene	2010	24634		
Physici	an/	Registrar	Douin	2. Date of Death		3. Time of Death		
Medical Exam		Robert Lee Lockett		August 5, 2		2058 hrs		
		Sinai Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	A		
Funeral Director		5. Social Security Number 219-80-1749 6. Sex 17. Age (In yrs. last birthday) 48 13 M 2 F	If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Birth Foreign Cou			
tuy		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion			10d. Inside City Limits		
Maryland 28a-f show any <u>1 at once.</u>	ō	MD N/A Baltimor	e			1 X Yes 2 No		
death with the Maryland or items 23a or 28a-f sho must be notified at once	Director		10f. Zip Code 21215		g. Citizen of What Count USA	ıv,		
	y Funeral		is Decedent of Hispanic Origin? (Si es, specify Cuban, Mexican, Puerto Yes 2 X No specify:		14. Race - Americ White, etc. African Specify: Amer			
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								
36 thin 72 lee. than "redical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Driver	,	Trucking			
21215-0036 Juld be filed within 72 hours after Mental Hygiene, marked other than "natural", c event, the Medical Examiner	Be	James A. Lockett		Belle				
Tina Queen/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 27 Leyland Court, Essex, MD 21221								
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is rn injury or other traumatic		1 Nation 2 Cremation 3 Removal from State Garriso	ition (Name of cemetery, her place) n ForestVA 8/		20c. Location - City or T Owings Mi			
Baltimore, permit. Pages I at Department of Hes Important: If ite injury or other tr		4 Donation 5 Other Specific 21. Signature of Fund of Jervice I censee 22. N 51	lame and Address of Facilit Har 26 Belair Rd,	i P. Cl Balt.,M	ose F.Svs	, PA 105		
Physician /Medical	failure. List only one cause on each line.							
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Complications of Ho	ead Injuries and	Neck In	juries	Death		
	ŗ.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated						
e executed sian and rial - transit		events resulting in death) Last Due to (or as a consequence of): d.						
O, be exection a sician a surial - 1	ədica	x unpended x amended 23a,27,28a-f #23a,perME,G908	per me g907 9-1 3-10/25/2010 WS	6-10 vt				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buril.	sician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe 4 Pregnant at time of death 5 Ott	tal death 3 Ectopic pregna		23d. Date of delivery Month Da	ay Year		
that the death	Phys	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tob	acco use contribute to the	e cause of death?		
P.O.	ģ			1 Yes	2 No 3 Proba	bly 4 Unknown		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed			24a. Was an autopsy perform	prior to co ned? death?	ppsy findings available mpletion of cause of		
ital Recionant The certificate rector, page	Be	25. Was case referred to medical	26. Place of Death (Check		1 7 103	2 110		
f Vit Physici er this o	유	Properties 1 Impatient 2 ER/Outpatient 2 Time 2 Ref. Outpatient 2 Sec. 7. Manner of Death 28a. Date of Injury 28b. Time of Ir			esidence 6 Other:			
ion o tending eath. or: Aft	To a be the second of the seco							
Division spital or Atten- cours after death neral Director:	28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Roor Town, State) 28f. Location (Street and Number or Rural Roor Town, State) 28f. Location (Street and Number or Rural Roor Town, State) 28f. Location (Street and Number or Rural Roor Town, State) 28f. Location (Street and Number or Rural Roor Town, State) 28f. Location (Street and Number or Rural Roor Town, State) 28f. Location (Street and Number or Rural Roor Town, State) 28f. Location (Street and Number or Rural Roor Town, State) 28f. Location (Street and Number or Rural Roor Town, State) 28f. Location (Street and Number or Rural Roor Town, State)							
To the Hosp within 24 ho To the Func completely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner:On the basis of examination and/or investigate	red at the time, date and place, and ion, in my opinion, death occurred a	due to the cause(s) and manner as stated	I. cause(s)		
To t with To tl	Medical	and manner stated 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont			
ik		lecture !] L	O.C.M.E.		August 5, 2010			
1		30. Name and address of person who completed cause of yeath (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Pen	n Street, Baltimore, MD 21	201				
St Regist	ate		1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 3:22 a Georgia Emma Lockhart August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Dove House Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 M 2 Months Hours Min. New York Sep. **Director** 86 <u>068-18-7546</u> Usual Residence of Decedent show 10a. State filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 X No Maryland | Carrol1 Westminster 10e. Street and Number 10g. Citizen of What Country? 23a Funera 370 Dora1 Court 21158 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3 🛮 Widowed 4 🗆 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing <u>Retail</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of Page 1 and 2 should be George Albert Conklin Pearl Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 370 Doral Court, Westminster, Maryland 21158 Health a Christine Krebs, Daughter Department of Heall Important: If item 2 any injury or other Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 8/5/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sagred tigilly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) use as the burial-transi and that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of). attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Tes 25. Was case referre 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ₩ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 🗌 Inpatient 2 🗀 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funera 1 XNatural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar 29b. Signature and the of certifier

AUG

062010

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month awsor 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign If Under 7. Age (In yrs. 8. Date of Birth (Month, Day, Months Min. Davs 1□M 2XF Hours laruland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify 3 Widowed 4 Divorced Slack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO,NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) [Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 22. Name and Address of Facility 30 Seph Rus 2722 Wi North 21. Şignatura of Funeral Service Licensee Bull uner Nor Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Appercalicemi disease or condition resulting in death) Due to (or as a consequence of) Metastic Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

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for

funeral director, page 2 should

Be Completed by

Medical Certification: To

attending physician

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has

certificate

this

After t

within 24 hours after deat To the Funeral Director:

filled in by

Hospital or Attending

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.✓

Physician

/Medical

Examiner

Director

Funeral

ğ

Completed

Be P

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

27 is marked other

or other Important: If item 2 any injury or other once.

Pages 1

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury

Exa	resulting in death) Last
Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1
О.	Part II Other significant

23b. Was decedent pregnant

9 Unknown

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

	examiner?
	1 ☐ Yes 2 No
ı	27. Manner of Death

31. Date filed (Month, Day, Year)

AUG 0 6 2010

1 Natural 2 Accident

3 Suicide 6 Could not be determined 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

45 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) Auguet, 05, 2010

MD

BaHiman

21229

Name and address of person who completed cause of death (Item 23a) (Type, Print) BUS

rain

2110 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7.8 per fh g906 8-12-10 yr State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:26 AM 010 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner Ltrmve Ba Imere 0 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1936 9. Birthplace (State or Foreign **Funeral** 1 №M 2 🗆 F Months Days Hours Min. Dav. Director Usual Residence of Deced 28a-f shov 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No more 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral items 13. Was Decedent of Hi Was Decedent Ever in U.S. Armed Forces?
1 ▼Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates Specify. Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) elt tome proveme Be 17. Father's Name (First, Middle, Last) မ permit. Page 1 and 2 should be Yh. (Son) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ro MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mills 4 ☐ Donation 5 ☐ Other (Specify) ð and Address of Facility 21. Signal o Funeral Service Licenses 22. N Balto North MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) oronar ea Medical Due to for as a consequence **Examiner** Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death certificate has been signed by the riector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗌 No Yes 1 Yes I Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 Tyes မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct

completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number H006810 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere -P SHOGAN 21215 PRISCI , D O 32. Registral's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 7 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4714 Henshaw Lane Pasadena Anne Arundel g. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours 05/26/1962 48 Kentucky **Director** 215-92-1104 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items 25a or 28a-f sho in injury or other thaumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 4714 Henshaw Lane 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify. Completed 3 - Widowed 4 - Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administative Assistant Investment Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vernon LeRoy Ulrick Judith Anne Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David LeCompte (Husband) 4714 Henshaw Lane Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burje 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Meadowridge Memorial Park 8/5/10 nation 5 Other (Specify) Elkridge, Maryland Farme and Address of Facility Funeral Home at MMP, 21075 21. Sign aure of Funeral Service Licenses 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 Be 26. Place of Death (Check only one) Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 1 ☐ Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 2 🗆 No Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29c. License number 29d. Date signed (Month, Day, Year, 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 11 per fh 8906 8-6-10 yr
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Donna Marie Langill 2. Date of Death Physician/ ugust Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham. Prince George's If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 075-62-9006 1 □ M 2 👿 F New York 49 Director 04/03/1961 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD 1 ☐ Yes 2 🛱 No Prince George's Riverdale 10f. Zip Code 10g. Citizen of What Country? 6516 Auburn Ave 20737 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 Xuo
If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes -2 ☐No Specify. → Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Grant Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Langill F. Joan Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. F. Joan Langill 738 Forest Hill Rd, Apalachin, New York 13732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Ardent Cremation, Inc 08/06/10 4 Donation 5 Other (Specify) Hanover, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) After this certificate has been signed by the functional director, page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD LUCK ROAD 31. Date filed (Month, Day, Year) 32 Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	te of Maryland /		rtment of H tificate of D			jiene Reg. No.	010	24640
Physici	an/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th	2010	3. Time of Death
Med Exami		Carmela T. Leddo 4a. Facility Name (if not institution, give street at			4b. City, Town, or	Location of Death	August	4c. Cou	2010 nty of Death Baltir	
Funera		Gilchrist Hospice 5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	g. Birth	place (State or Foreign
Directo		217-20-7374 1 ☐ M 2 Usual Residence of Decedent	84 84	Yrs.	Months Days	Hours Min.	July 11,	1926	BaÎt	Maryland
Aaryland 8a-f shov tified at	rector	Maryland Baltimore	10c. City, Tov	wn or Loc ckey	sville		- "			10d. Inside City Limits 1 ☐ Yes 2 🎑 No
with the A 23a or 2 ust be no	Funeral Director	10e. Street and Number 10315 Greenside Driv	re		10f. Zip Code	1030		10g. Citizen o Unite		ntry? tes
partition (e), Mary yielly 4 14.13-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and the medical Examiner must be notified at	₽ P	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces? I Yes 2 🔯 No es, Give r or Dates.	If	/as Dec ed ent of His Yes, specify Cubar ☐ Yes 2 X No	, Mexican, Puerto	cify Yes or No-	14. F	Race - Ameri Black, White, Bify: Wh	etc.
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be filed w ental Hygi rked other	To Be (17. Father's Name (First, Middle, Last) Joseph DaCampo	I			18. Mother's Name	e (First, Middle, I 'errara			
d 2 should alth and M 127 is mar		19a. Informant's Name/Relationship (Type, Prin William J. Leddon/ so		b. Mailing	g Address (Street a.	nd Number or Rura	l Route Number, re Cock	City or Towr	n, State, Zip le, M	_{Code)} 21030 aryland
t. Page 1 and tment of He tant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	I from State F.Van	ery, crem	sition (Name of atory or other place neral el Air	Augus		20c. Location	,	own, State Maryland
permit. I Departm Importa any inju		21. Signature of Juneral Service Licensee	TCTAPE		Name and Address		meral and	d Cremet	ian Ce	nter, P.A.
Physician		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	s that caused the death. Do on each line.		the mode of dying		or respiratory arre		210).	Approximate Interval Between Onset and Death
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uted d ansit	Examiner	Sequentially list conditions, lf any, leading to immediate cause. Ente, Underlying Cause (Disease or iinjury that initiated events	ue to (or as a consequence	of):						
poste be executed physician and the burial-transit	edical Ex	resulting in death) Last	ue to (or as a consequence	of):						
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uires that the signed by	by	Part II. Other significant conditions contributin	g to death but not resulting	j in the ur	nderlying cause give	en in Part I.		3 4		the cause of death?
or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transition.	Completed						24a. Was a autop: perfor 1 \(\subseteq \text{ Yes} \)	sv	prior to co death?	opsy findings available ompletion of cause of
Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ ER/C	N. 4 11 4	Othe	ce of Death (Checker:	(only one)			
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To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director. After th completed filled in by the funeral	Certificate;	3 Suicide 6 Could not be	Place of Injury - At home, f building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town		mber or Rura	al Route Number,
he Hospit in 24 hour he Funera	Medical	29a. Certifier 1 Certifying Physician: Ti (Check 2 Medical Examiner: On only one) 3 Certifying Nurse Pract	he basis of examination and	or investi	gation, in my opinior	n. death occurred at	the time, date an	d place, and	due to the ca	ause(s) and manner stated.
To t with To t		29b. Signature and title of certifier All All All All All All All All All Al	d cause of death (Item 23a) 32. Registrar's Signature		29c. License	Number 8303		AVS VS	ned (Month,	Day, Year) Zelu
		30. Name and address of person who complete	d cause of death (Item 23a)	(Type, Pr	larly	ST T	WSON	M	7	
Sta Regist		31. Date filed (Month, Day, Year) AUG 0 6 2010	32. Registrar's Signature	bar	KN					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 22:08 M LANSINGER 08 VIRGINIA 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF N/A MARYLAND HEDICALCTR BALTIMORE 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🕇 F Months Hours (Month, Day, Year 86 220 18 4952 Maryland Director Usual Residence of Decedent sa or 28a-f show be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director **Baltimore** Anne Arundel Maryland 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral 21225 U.S.A. 227 W. Arundel Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Sales Person Retail / Dept. Store 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever ပ Ralph M. Cline Catherine Estelle Rine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Stalnaker / Daughter 317 - 10th Avenue Baltimore, Maryland 21225 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 08/05/2010 Marriottsville, MD. 4 Donation 5 Other (Specify) Crestlawn Cemetery of Juneral Service 21. Signatu Gonce Funeral Service, P.A. 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) EPTICEMIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Pregnant at time of death Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes Hospital or Attending Physician; 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural injury 5 Pending Accident Investigation 1 Yes 2 No Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) NPI 1548446495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE

DHMH 17 Rev 7/2009

State Registrar

GREEA

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19 Day Physician/ 2000 200 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Georges chevert. Misce Prince Hospita 5. Social Security Number If Under 1 Year | If Under 24 H/s. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1+11 1 Yes 2 No Md Oxon 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: Blac If Yes, Give 1 ☐ Yes 2 🗷 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ec. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) -24-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of Funeral Service License 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner COSC Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 🗌 Yes AがB+F Pら Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examine*? Hospital Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 🕽 🗥 Certificate: 28c. Injury at (Month, Day, ☐ Natural 5 Pending motorcycle, lost conti 12010 1 Yes 2 No Investigation 3 Sulcide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the least of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practione: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryla						01610	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eatn	eg. N2. 0 1 0 2 4 5 4 3			
4	Physici /Medio		William 4a. Facility Name (If not Institution, give stre	ot and number	Lo	4b. City, Town, or		2. Date of Death Month	Day Year 02 2010 4c. County of Death	2:50 A M	
J	Examir	er	The Johns Hopkins Hos	· ·		Baltimore			N/A		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday) 1 Yrs.		If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, You 03/15/1	'ear) Cou	place (State or Foreign ntry) YLAND	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	ation				10d. Inside City Limits	
	Maryl a-f sho iied at	ţo	MD N/A		BALT	MORE CI	TY			X Yes 2 □ No	
	or 28.	Director	10e. Street and Number			10f. Zip-Code		10g	g. Citizen of What Cou	ntry?	
	eath w	Funeral	2035 E. FAIRMOU	JNT AVENUE Was Decedent Ever in U			1231	necify Ves or No-	U.S.A.	can Indian	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cubar	Specify:	o Rican, etc.)	Black, White		
2-0	72 hou natura lical E	eted	15. Decedent's Educa (Specify only highest grade o		(Give I	ent's Usual Occupa			6b. Kind of Business/I		
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	OO NOT use retired) DISABLE	D		N/A		
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ylar	ould by Menta arked atic ev	2		RIMORE					HAVIS		
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (<i>Type</i> . DEBRA WRIGHT/ S]	STER		,			Cify or Town, State, Zi	•	
	s 1 and 2 of Health item 27 i		20a. Method of Disposition	20b.	Place of Dispos		i		MARYLAND Oc. Location - City or 1		
<u>=</u>	Page ment c ant: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	OLY CE	OSS CEM	ETERY	8/10/10	BALTIMOR	E, MARYLANI	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Genice Licensee	of for	2 ² 1 1	Name and Addres ILLY & 901 EAS	s of Facility ZETLER TERN A	INC. FU VENUE, BA	NERAL HO LTIMORE,	ME MD 21231	
			23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of	ions that caused the dea ause on each line.						Approximate Interval Between Onset and Death	
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	Examiner		Companies II. list conditions	liver failur	e						
	sit ad	Examiner	Sequentially list conditions, if y a light conditions cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		1. 0 .					
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8760,	ysiciar ne buri	dical	d								
9	ertificat ng phi e as th	w	IF FEMALE:								
P.O. Box 6	The law requires that the death certifics te has been signed by the attending phage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year	
	ires that t signed by id be deta	by	Part II. Other significant conditions contril	outing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did toba 1 ☐ Yes	acco use contribute to	the cause of death?	
SCO	law require ts been sig	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of	
<u> </u>	The lay	Com						performe	ed? • l death?	2 1 No	
Vita V	sician: Tr certificate irector, pa	Be	25. Was case referred to medical examiner?	pital:		3 DOA Other		th (Check only one)			
ō	Phys r this c eral dii	은	27. Manner of Death	' 1 ☑ Inpatient 2 L 28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury	at Nulsing I	ome 5 Residence 28d. Describe how	ce 6 Other (Speci v injury occurred	fy)	
Sion	anding tath. rr: After he fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 7	es 2 No				
Division of Vital Records,	I or Attending Physician: after death. Director: After this certifica d in by the funeral director,	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci		et, factory, office		28f. Location (Stre Cify or Town, S	eet and Number or Ru State)	ral Route Number,	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Co	29a. Certifier Certifying Physici (check only one)	an: To the best of my kno : On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)	
	To the within To the COMP	Me	29b. Signature and title of certifier	7		29c. License	number	290	d. Date signed (Month	Day, Year)	
			NIVI			RES	- 000	A	ugust 02	,2010	
			30. Name and address of person who com William Brian	bleted cause of death (Ite	em 23a) (Type, I	Print)	600	North Wolfe	→ e St, Baltimo	re, MD, 21287	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	tares						
	negistr	üΙ	AUG 0 6 2010 Le	some in in	ears						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3:53A M 3, 2010 August Michelle C. LeComte /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Mt. Airy
If Under 1 Year | If Under 24 Hrs. Kline House 8. Date of Birth (Month, Day, Apr 2, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F Washington, DC 58 1952 264-92-2450 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2X No Director Montgomery Village Maryland Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States Funeral 20514 Strath Haven Drive 20886 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White <u>}</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Editor Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F Pages 1 and 2 should be Ralph Michael LeComte, Jr. Antoinette Mackall ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a R. M. LeComte/Brother/Exec. 3827 Round Tree Road Jefferson, Maryland 21755 other or other Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition jo 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State permit. Page Department o Important: I any injury o once, Final Journey Crematory 8/5/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of Funeral Service 22. Name and Address of Facility Going Home Cremation Service P.O Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 nomao Approximate Interval Between Onset and Death 23a. Part in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) eiomyosarcomo **Physician** , /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, burial-tran Due to (or as a consequence of) physician Physician/Medical as the attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 XNo the 9 Unknown 9 Unknown þ signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 300 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident 24 hours after deat • Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rederick, mi State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Marie Anna Lotsey 2010 11:00 PM August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Genesis Heritage Meridian Care Ctr Dundalk 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 √ F Months Hours 219-10-0795 84 Director .1925 Maryland Jsual Residence of Decedent marked other than "natural", or items 23a or 28a-f shov matic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Baltimore Dundalk 1 ☐ Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2510 Gray Manor Terrace 21222 United States should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married þ ☐ Yes 2XXNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 7 Years Be unkn. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna William Hilker other traumatic .. Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8369 Forest Drive Pasadena, Maryland 21122 Ava L. Magrogan (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 8/4/2010 Hilltop Service Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk. Maryland 23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEART FAILURE Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) HNASARCA requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last FAILURE RESPIRATORY physician Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗆 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown 2 🗌 No Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ns certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 🗹 No Physician: 25. Was case referred to medical Be 26. Place of Deat - heck only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and on involving spaces, and graded at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

AUG 0

Market Place Dundale MD

State of Maryland / Department of Health and Mental Hygien ? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26 10 10:58 AM Gloria Iris Marble AUGUST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TOWSON BALTIMORE MEDICAL CENTER SAINT VOSEPH 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth 6 Sex Funeral Days July To Year) 1930 San Juan, PR 1 🗆 M 2 🗶 F 581-01-8959 80 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 □ No Maryland Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6015 Western Run Drive 21209 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 1 X Yes 2 □ No Specify: Puerto Rican Specify: Hispanic 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Margaret Unknown Raymond Tavarez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Foster Knoll Drive, Joppa MD 21085 Tammy Baczynskyj/ daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 W Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery | 08/09/2010 Pikesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Towson, MD 21204
Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) **Examiner** CHRONIC OBSTRUCTIVE PULMONARY DISTASE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury LUNG CANCER Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART FAILURE Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CIRRHOSIS 24a. Was an 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: 흔 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural Accident injury 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31824 wit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 7601 OSLER DRIVE TOWSON RICHARD LINTHICUM 31. Date filed (Month, Day, Year) State

Registrar

AUG 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug. Physician/ 6, 2010 5:50 Ам Moralis Sarah Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore <u>Gilchrist Center</u> Towson 5. Social Security Number 6. Sex 1 ☐ M 2 💢 F 8. Date of Birth (Month, Day Ye Aug. 20, . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral ^{Year)}1929 Days Months Min. Hours A Tabama Director Yrs 80 418-34-4288 Usual Residence of Decedent or 28a-f shov 10a. State with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Hunt Valley Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 400 Symphony Cir. Apt. 264A 21030 filed within 72 hours after death and Hygiene.

I other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 X XNo Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2XXNo Specify: Specify: 3 X Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file n and Mental H **7 is marked ot** Angelike Moumouris Constantine Vrachalus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If Item 27 is any injury or other trau 400 Symphony Cir. Apt.264A Hunt Valley, Md. 21030 Rev. Constantine Moralis/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/11/10 Woodlawn, Maryland Greek Orthodox Cem. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or contilications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Alzheimer's Dementia rear s disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ Dav 1 Urknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law prior to completion of cause of death? performe 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practices 15-15 best of my moviledge, cash occurred at the time, date and place, and the cause(s) and manner stated Certifying Number Practices 15-15 best of my moviledge, cash occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practices. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0070le

DHMH 17 Rev 7/2009

State Registrar Charles St

32. Regist s Si

Baltimore

2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(0)

Parte

31. Date filed (Month, Day, Year) AUG 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24648 State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:47 AM Maria Mackey 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Union Memorial Baltimore na Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Min 12-10-1924 1 □ M 2**X**□ F 85 213-36-0657 Director VA Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 644 Dumbarton Avenue 21218 U S Α 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after obpartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: 3 Widowed 4 □ Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Day Care 8th grade <u>Self Employed</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Lottie Lee Jones Robert Drummond 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Hill-Daughter 1702 Kennoway Road Balto, MD 21234 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Timonium, 8-9-2010 4 Donation 5 Other (Specify) Dulaney Valley 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H (Josephon Million 1101 E. North Avenue Balto, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition uran Medical resulting in death) ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g A Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director, completed filled in by the f Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day AUG 0 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
EMILY ERYAN 201 University Parkway Buttimae MD 21218 32. Registre's Signature

AT2438946B11

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 040 AM 2010 /Medical 4c. County of Death 4a. Facility Name (If not Town, or Location of Death **Examiner** mmunity der 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6-14-1926 Birthplace (State or Foreign **Funeral** Months Hours Min **1**00 M 2 □ F 84 Ohio **Director** 275-20-0449 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evantinar it ust be notified at 1X Yes 2 □ No Director Baltimore MD na 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21217 Dolphin Street S Funeral 501 Α 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry na Elementary/Secondary (0-12) College (1-4or 5+) na 6th grade 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any liquy or other traumatic event once. Be 17. Father's Name (First, Middle, Last) unk Louise Morgan ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 501 Dolphin Eloise Thomas-Friend Street Balto, MD 21217 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8-10-2010 Garrison Forest Owings Mills, MD 21. Signature of Foneral Service Licensee March East F/H 22. Name and Address of Facility Drawfull When 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of After this certificate 2 🗆 No 1 □ Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Certification: To 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐Yes 2 ☐No il Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ithin 24 hours after of the Funeral Directory in the Funeral Directory in the funeral by determined 4 ☐ Homicide Hospital 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 To the I 29d. Date signed (Month, Day, Year) ature and title of ca 29b. Sign 29c. License number of death (Item 23a) (Type, Print) 3900 Lo odo State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sarah H. Masterson Month Day 08 04 2010 2:11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Annapolis If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min 11/16/1923 Scotland 1 ☐ M 2**X**☐ F 86 Director 138-24-9639 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NJ Camden Gloucester City Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 08030 430 S. Broadway, Apt. 312 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dwn Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John H. Stafford Mary Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Woodlane Dr. Westville NJ 08093 19a. Informant's Name/Relationship (Type, Print) James Masterson (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Cinnaminson, NJ Lakeview Mem.Park. 8/9/10 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2426 Cove Road Pennsauken, NJO8109 Inglesby & Sons F.H. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Hemorrhaeiu disease or condition Medical resulting in death) Due to (or as a conseque de Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has boom since the continuation of the continuation attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events 9-01,90 Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: ပ ER/Outpatient 3 DOA 1 impatient 2 -4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 M Natural 5 Pending 1 Tes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 2010 D.C.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goulet

31. Date filed (Month, Day, Year)

600

Ridgel

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-05546 Rheo Lemar Kendall McCain State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day July 24, 2010 2241 hrs Medical Examiner Rheo Lamar Kendall McCain 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Havre de Grace Harford Harford Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Davs Hours 7-11-1988 Country) MD Director 22 216-21-5251 Yrs 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No s 23a or 28a-f show e notified at once. 28a-f show Baltimore MD na Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 USA 1211 Linworth Avenue Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black *natural" <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) na t. Pages I and 2 should be filed within 72 h trment of Health and Mental Hygiene. tant: If item 27 is marked other than "n or other traumatic event. the Medicar Elementary/Secondary (0-12) College (1-4 or 5+) na 2th grade 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Mary McCall Barry McCain æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1211 Linworth Avenue Balto, MD 21239 Hazel Evans-Grandmother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7 - 31 - 2010Randallstown, King Memorial Pk 4 Donation 5 Other Specify: East F/H March 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Balto, MD 21202 1101 E. North Avenue 23a. Perrit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medica Death Immediate Cause (Final disease a. Drowning Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED 23a, 27, 28a-f, per me, g918 8-11-11 sm X UNPENDED the attending physician ed for use as the burial certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown 23e. Did tobacco use contribute to the cause of death? <u>о</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has death? performed 1 🗸 Yes page Yes 2 No 2 No certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25 Was case referred to medical Vital æ examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other: Nursing Home 5 Residence 6 Other: DOA this 2 No 1 Yes ۵ ٥ 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? After Certification 1 Natural Division 1 Yes 2 No Pending Director: subject jumped in water the fd 2234 hrs fd 7-24-10 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 354 Commerce St. Pier2 Havre De Grace, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide (Specify) public park/marina Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 25, 2010 O.C.M.E. M 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D.

State Registrar

31. Date filed (Month, Day, Year)

0.6 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 24652 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician /Medical 10:15 AM Maher Francic 2010 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Ye Sept 23 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ▼M 2 □ F 214-40-7688 67 MD **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10h Chunts 10c. City, Town or Location York traumatic event, the Medical Examiner must be notified at PA Hanover 1 ☐ Yes 🐰 ☐ No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 115 Fairview Drive 17331 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No 1968 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) printing printer 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Woodrow Wilson Maher Margaret A. Cunningham ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mary J. Maher (spouse) 115 Fairview Dr., York, PA 17331 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Memorial 20c. Location - City or Town, State 8-7-10 Marriottsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SOUS Sundrom disease or condition /Medical resulting in death) Due to (o as a consequence of) Examiner Sequentially list conditions, Examiner cause (Disease or injury Due to for es a nonsequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Vunknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 NO 2 ER/Outpatient 3 DOA ၉ 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation aral Director: After filled in by the fune 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Hugust 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) inders 600 North Wolfe St, Baltimore, MD, 21287 Beni 9 Min 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			for State Registrar	State o	f Marylan		artment of rtificate o	Health and f Death	-	giene Reg. 2 .0	10	24653	
	Di Litt		1. Decedent's Name (First, Middl	e, Last)					2. Date of Dea	ath Day	Year	3. Time of Death	
	Physici: /Medic		Parker F	rancis	Marsha	11, Jr	•		August		2010	20:31 P M	
and the same	Examin		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town	or Location of Dea	_	4c. Coun	ity of Death	h	
1			Washington Adv	entist Ho	spital		Tal	coma			ntgome	ery	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Yea Months Day			h v, Year)	9. Birth	hplace (State or Foreign untry)	
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	shor	<u> </u>	10a. State 10b. County		100. 010	y, Town or Lo	cation					1 Tyyes 2 □ No	
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	/ith ti	ä	10e. Street and Number 10f. Zip Code 10g. Citi								tizen of What Country?		
	ath v	ra	519 Ingraham					20011			USA		
	er de	Funeral Director	11. Marital Status	Armed Fo		S. 13. \	Nas Decedent of Yes, specify Cu	f Hispanic Origin? (Jban, Mexican, Puel	Specify Ye's or No- rto Rican, etc.)	- 14. R Bl	ace - Amer lack, White	rican Indian, , etc.	
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D	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exactive count be cofflished at	Ö	17. Father's Name (First, Middle,	Last)			OICIN	18. Mother's Na	me (First, Middle,			02,1200	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of Hygiene. Departme	o Be	Parker Francis	Marshall	. Sr.			Martha '	Thompson				
<u></u>	shoul nd M mark	ပ	19a. Informant's Name/Relations		,	19b. Mailir	na Address (Stre	et and Number or F	_	er. City or Tow	n. State. 2	(ip Code)	
Z	id 2 s lth al 27 is 1 trau		Audrey L. Marsh			1		Street,		nington	-	20011	
ē,	Hear Hear tem	1	20a. Method of Disposition		20b. F		sition (Name of natory or other p		Date	20c. Location		Town, State	
J0	ages ent o it: If i		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State			i	0/2010	T J	T	dament and	
₫	artme ortan injur		21. Signature of Funeral Service		har			Park: 8/10 Iress of FacilityMa				Maryland L Home	
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	.	П 3	shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.		+ ,	21				Interval Between Onset and Death	
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ŏ	andin use	2	IF FEMALE; 23b. Was decedent pregnant		come of pregna		7			23d. [Date of deli	ivery	
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ta	an; T		25. Was case referred to medical		Coller	•		26 Place of Do	1 ☐ Yes eath (Check only o	2 INo	1 Ll Yes	2 □No	
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6	al or	Certification: To	4 Hornicide	buildii	ng, etc. (Specir	y)			City or Tov	vn, State)			
	To the Hospital or Attending Physician: The law requires that the death certifulth 24 hours after death servines that the security of the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifyir (Check only 2 Medical	g Physician: To the	best of my kno	wledge, death	n occurred at the	time, date and place	ce, and due to the	cause(s) and	manner as	s stated.	
•	n 24 n 24 n 24 ne Ft	edical	one)	Examiner: On the b and mani	asis of examina ner stated.	ition and/or in	vestigation, in m	y opinion, death occ	curred at the time,	date and plac	e, and due	to the cause(s)	
i	With With Son To the tenth of t	Ž	29b. Signature and title of certifie	114			29c. Lice	nse number		29d. Date sign	ned (Montl	h, Day, Year)	
				MD			4	1861		8/3/	W.		
			30. Name and address of person	who completed caus	e of death (Item	n 23a) (Type	Print)	u ->	2-61-51		,	000	
			Unay Zun	180,47	OLKAI	ndolp	h Rd x	7867 #216. K	OCKULI	E, M	00	0016	
	Sta Registra		31. Date filed (Month, Day, Year)	62010 32.7	gistrar's Signa	ture	and						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24654 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2010 Christine Germaine Murray 2:15 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5517 Edna Avenue Baltimore Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Hours 09-29-1949 Director 60 Maryland 214-54-3102 Usual Residence of Decedent show 10b. County items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland N/A <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5517 Edna Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 - Widowed 4 X Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Heelth and Ment. Important: If item 27 is marked any injury or cat. Arthur Madore Elizabeth Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Michelle Popp - Daughter 6843 Mt.Vista Road Kingsville, MD 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State Hilltop Service Corp! 08-06-2010 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Sa 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a Part 1 Approximate Interval Between guamus Cell Cancer of Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmman Obstructive 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe is after death.

al Director: After this certificate ha led in by the funeral director, page 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de **To the Funeral Directo** completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine Isma O'Mahony $20\overset{\text{Year}}{10}$ 6:45 P M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery General Hospital Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Month, Day, 1 M 2XXF Months Hours Min. Country) Washington DC 68 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Montgomery Sandy Spring 1 Tyes 2 No 10f. Zip Code 6 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 17340 Quaker Lane 20860 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or þ 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify. White Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Worked 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William J. O'Mahony Grace Martha Hare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace A. Hosker / Sister 15101 Interlachen Dr. Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory: 8/5/2010 Beltsville, MD Signature of Funeral Sa 22. Name and Address of Facility
Rapp Funeral and Cremation Services 20910 Gist Ave. Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jepsi) Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): g physician a s the burial-Physician/Medical Box 68760 ending p IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) atten for u in the past 12 months?

1 Yes 2 No Month Dav signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law Jas autopsy certificate ha irector, page 2 performed? Yes 2 \(\subseteq \text{No.} \) death? 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 X No 1 Yes ည 1 Dopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 1 Natural 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar

State

1201 SEVEN LOCKS RD #200

32. Registrar Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D68658

KOC RUILLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Eacility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death WITIMPE 8 Date of Birth ecurity Numbe st birthday) If Under 24 Hrs. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 Months Hours Min. DOO INA Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Baltimore permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No 10e. Street and Numb 10g. Citizen of What Country? Funeral 1216 00 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 2 No 1 Tes Specify 3 Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) onday (0-12) College (1-4 or 5+) Be Maryland Father's Name (First, Middle, Last) Mother's Name (Fit t, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 29c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of uneral Service Lice 15 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock/or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Filysician END STAGE RENAL DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use a 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 **X** No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **X** No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier □ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar JACKIE JONES,

31. Date filed (Month, Day, Year)

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2010

ANNIE

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

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			1 - State Registrar		,		rtificate of				leg. No. 2010	24657
	Physici	an	1. Decedent's Name (First, Mid	ddle, Last)					2.	Date of Dea Month	th Day Year	3. Time of Death
An.	/Medio		HELEN 4a. Facility Name (If not institut	I. ition, give street and number		ACEK	4b. City, Town, o	r Location (UGUST	4, 2010 4c. County of Dea	4:45 P.
M.	Lxaiiii		CARROLL HOME				WESTMI				CARROLI	
ı	Funeral Director		5. Social Security Number 219-07-8373	6. Sex 1 ☐ M 2 💢 F	Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Date of Birth (Month, Day 5/31/1		rthplace (State or Foreign Country) ARYLAND
	σ		Usual Residence of Decedent 10a. State 10b. Cour	ntu		ty, Town or Lo	nation			7/31/1	920	10d. Inside City Limits
	Maryla -f shov led at	tor		RROLL		HAMPST						1 ☐ Yes 2 ▼ No
	th the or 28a e rotif	Funeral Director	10e. Street and Number	4.000			10f. Zip Code			1	log. Citizen of What C	ountry?
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	il Hygie other	Be Co	5TH GRADE 17. Father's Name (First, Midd	lle, Last)		CROS	SING GUAF		er's Name <i>(F</i>	irst, Middle,	Maiden Surname)	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the M	T0 E	WILLIAM H. K	UCHLING					CE_SIL			
Mar	d2sh Ith and 171sm traum		19a. Informant's Name/Relation JOHN PLACEK/S				ng Address <i>(Street</i> OVERVIEV			oute Numbe PSTEAD	r, City or Town, State, MD 2107	
ore,	es 1 and 2 of Health item 27 I		20a. Method of Disposition		20b. F		osition (Name of matory or other pla		Date		20c. Location - City o	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 amy Injury or other tr		1 ★ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	on 3 Removal from State (Specify)		. STAN	ISLAUS CE	EM.	8/7/20		BALTIMORE,	
Ball	permit. Pages 1 Department of the Important: If ite amy Injury or of		21. Signature of Funeral Servi	ice Licensee MOO21	7	1	2. Name and Addre					HOME, P.A. 21286
-	Physician		23a. Part 1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition	, or complications that laus list only one cause of each	ed the deat	h. Do not en	ter the mode of dyi	ng, such as	cardiac or re	8	rest,	Approximate Interval Between Onset and Death
뒴	/Medical Examiner		resulting in death)	Due to (o)	as a conseq	uence of):	E/11/1	TU	4			
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a conseq	uence of):	400	-				
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C								
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ds, P.	uires that the de signed by the d be detached		Part II. Other significant cond	ditions contributing to dear	but not res	ulting in the u	nderlying cause giv	ven in Part I	l.	23e. Did to		to the cause of death?
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E Be	lan: The law rtificate has stor, page 2 s	Comi				-				autop: perfor 1 🗆 Yes	med? death?	
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	To the within 2 To the comple	Me	29b. Signature and title of cert	ifier lu	CV	My	29c. Licen	se number	Bi		29d. Date signed (Mon	nth, Day, Year)
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			1 - For State Registrar	State of Ma		d / Depa		of He	alth and	-		Z U I U I	24658
		700	1. Decedent's Name (First, Middle, Las	st)						2. Date of Month		ay Year	3. Time of Death
	Physic /Medi		Lois Ann Parker							Augus	_	2010	11:20 A ^M
	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, To	own, or Lo	ocation of Dea	ath	4	c. County of Deat	
			Harford Memorial						Grace			Harford	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs.	last birthday)	If Under 1 Months		f Under 24 Hr Hours Mir	n. (Month,	Day, Yea		hplace (State or Foreign untry)
	Director		152-22-1237 Usual Residence of Decedent		80	Yrs.				June	13,	1930 New	Jersey
7-	and		10a. State 10b. County	_	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
Also	Aaryl Fsho	ö	New	-	Nor	th Pla	infial	3					1 ☐ Yes 2 No
	28e-	ect	Jersey Somers 10e. Street and Number	a	IVOL	CI IIa	10f. Zip C				10g. C	Citizen of What Co	untry?
08/03/10 036	ours after death with the Maryland raf, or Iteme 23a or 28e-f show Exacting man be cotified at	by Funeral Director	195 Stahl's Way										•
2	leath	era	11. Marital Status	12. Was Decedent E	ver in U	.S. 13. 1		060	anic Origin?	Specify Yes or orto Rican, etc.)		S.A. 14. Race - Ame	rican Indian,
200	ē = <u>5</u>	E	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo			_			irto Rican, etc.)		Black, White	
33 8	urs a	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 28	∆ No	Specify:			Specify: Wh	ite
DOD 08 21215-0036	within 72 hours after ene. than "natural", or ite	Completed	15. Decedent's Ed	ducation		16a. Dece	dent's Usual	Occupation	on .	- 41	16b.	Kind of Business/	Industry
22.5	hin 7 In "n	ple	(Specify only highest gra	College (1-4 or 5+	-)	lite.	DO NOT use	retired)	ing most of w	onking			
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\ <u>D</u>	oth oth	Be	17. Father's Name (First, Middle, Last)					18	3. Mother's N	ame (First, Midd	dle, Maide	en Sumame)	
ें ब	Aenta Aenta rked	10	Grover F. Kipsey					E	lise A	. Kuebl	er		
13/30 , Maryland	s 1 and 2 should be filed within 72 hours af the Health and Mental Hygiene. The Table 127 is marked other than "natural; or other traumatic event, the Medical Example.		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street and	d Number or I	Rural Route Nur	nber, City	or Town, State, 2	Zip Code)
	C = M =		Ms. Amy J. Parker (1	Daughter)		502 O	unten	nint (ir. Hav	re de Gra	œ, M	aryland 210	078
ク/ラ <i>つら//૩/ラ</i> の Baltimore, Marylan	S 1 a of He other		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	of		pate ust 6,		Location - City or	
~	Page ent c nt: M		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐		Eva	remetery crem ns Funer Bel –	al Chap Air	er ,	, –	2010	For	rest Hill,	Maryland
$\mathcal{O} \stackrel{\mathbf{Z}}{=}$	oartm oorts inju		21. Signature of Funeral Service Licer	·				Address			_	rvices - Be	
DOD	Ped In Ped		I Selley R	Patriner	1					t Hill, M			el Air
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<u> </u>	The I	E	Seizure	•						pe	rformed	death?	2□ No
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0.	Physician: r this certifica ral director, p	To B	examiner? 1 Yes 2 10	Hospital:	t 2	ER/Outpatier	nt 3□ DOA	Other	4 Nursing	Home 5 ☐ R	esidence	6 ☐Other (Spe	cify)
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			Vister	Cour 1	211	2		000	598	35	1	tua 3r	d, 2010
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIAM POWELL Manin EARL. 8 2134 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Lanham Doctors Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ☑ M 2 🗆 F Months Days Hours (Month, Day, Year) 39 Country) DC Director Sep 70 578-52-6293 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merell Hyglene. Important: If tiene ZT is and Merell Hyglene. Important: If tiene ZT is and Merell other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Upper Marlboro MD Prince Georges 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20772 5605 South Marwood Blvd. #109 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: **Black** 3 Midowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Univ. of MD Truck Driver 7th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Jones Walter Powell, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2077219a. Informant's Name/Relationship (Type, Print) 5605 South Marwood Blvd. #109 Upper Marlboro, MD Sylvia Coates - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 8-2-2010 Brentwood, MD. Signature of Junaral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th St. Washington, NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HYPERPYREXIA Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is the account of the cause) Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the at the detached for Yes 2 | No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 Yes 2 No 3 Probably 4 Onknown Completed STROKE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an nas autopsy DIABETES performed After this certificate 2 1 No 1 Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shobhit rood

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 24560 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 17:55 POPOK GRIGORY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Mospital imore Baltimon If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 215**–**94–2786 **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. 0771271938 72 Director RUSSIA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 290 and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6976 MILBROOK DRIVE, #2B 21215 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. WHITE Specify: Completed 3 Widowed 4 □ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEERING ELECTRICAL ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ POPOK RACHIL DUCOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 885 CAREN DRIVE, ELDERSBURG, MD LANA POPOK/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State BALTIMORE HEBREW CEM. 08/04/2010 REISTERSTOWN, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Chronic Physician/ distase YCAY disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 241 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine After this certilicate has been signed by the attending physician and funiral director, page 2 should be detached for use as the burial-transit cars Cause (Disease or linjury that initiated events Hypotens: on Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 💢 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Hospital or Attending Pl
 4 hours after death.
 Funeral Director: After th 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending injury Accident Investigation 2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signatur

eamrat

31. Date filed (Month, Day, Year)

Sinai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2010

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - \Year Month Physician Dorothy Kenney Rohmer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Dulaney Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 104 Director 064-07-8053 Nov 02, 1905 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director MD Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code d 2 should be filed within 72 hours after death with fin and Mental Hygiene.
77 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a traumatic event, the Medical Examiner must be a 21050 United States 1811 Campbell Rd. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Sales Representative F Health and Mental Hy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျ William Kenney Irene Hauser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barney Bafford /Grandson 1811 Campbell Rd. Forest Hill, MD 21050 permit. Pages 1 ar Department of Heal Important: If item 2 any Injury or other Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State റദ Aug 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland 2010 Chesapeake Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Cremation and Funeral Alternatives Robecco 10 Mor 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause neach line. Immediate Cause (Final disease or condition resulting in death) **Physician** eme /Medical Due to or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 212/No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this Hospital or Attending Ph
 24 hours after death.
 Funeral Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Cruifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dundalk Ave Battimone, MD 24222 t Sadi , 31. Date filed (Month, Day, Year) State AUG () Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ : 30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Princ Ba 70000 ano 7. Age (In yrs. last birthday) 9. Birthplace (State or Fereign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Min (Month, Day, Country) Director 1ax Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1XYes 2 ☐ No 10g. Citizen of What Country? Funeral 14000 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced Completed White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Constructi any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည orenzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20715 Simpson Margaret 20a. Method of Disposition duenter 14000 ane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify)
21. Signature of oner Service Licens Balto 22. Name and Address of Facility 1232 Midvalley Dr. Jessep, PA18434 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory frest or heart failure. List only one cause on each line. Approximate Interval Between shou Imme Lie Cause (Final disea or condition resulting in death) Infaretion Onset and Death Muocardial Physician/ Mullediat Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyper Jeusion 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed Anoveria Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined completed filled in 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and the superior of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier unte HO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e do 115 centerway 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Juj Vear **Physician** 2011 William Thomas Richardson Sr. /Medical 4a. Racility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** y Number If Under 24 Hrs. If Under 1 Year 9. Birthplace Country) 5. Social Security 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1 ☑ M 2 ☐ F Feb. Director 18, 1933 Maryland 212-30-5997 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show ortant; If item 27 Is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, Its. Medical Examiner must be notified at 1XYes 2 □ No Director Harford Bel Air Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 35 W. Broadway USA Funeral 21014 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baker Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Clarence Lee Richardson Mary Marlene Hicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Richardson / Wife 35 W. Broadway, Bel Air, MD 21014 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gdn. 8-4-10 Bel Air, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
McComas Funeral
50 W. Broadway, Home, P.A. Bel Air, MD 21014 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call Approximate Interval Between Onset and Death Altheiners Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Mexinsier law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician for use as the buria Box 68760. ascu Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the signed by t t be detach Part Ih Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 anger 2 No 3 Probably 4 Junknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No noThymais 24a. Was an cate has t page 2 s certificate 1 □Yes of Vital 2 🗆 № 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₽ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide within 24 hours after
To the Funeral Dire
completely filled in by 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 110 3 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) ewis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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			_ State	of Maryland / Dep	artment of rtificate of		and M		- 21	110	24564
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	uncate of	Death		2. Date of Dea	Reg. No.		0.7: (0.1)
Н	Physicia		, , , , , , , , , , , , , , , , , , , ,	Davia						110 ^{Year}	3. Time of Death 2:10 PM
	Medic										
	Examir	ier	4a. Facility Name (if not institution, give street and number) NATIONAL INSTITUTES OF HEALTH 4b. City, Town, or Location of Death BETHESDA								ERY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth			thplace (State or Foreign untry)
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	nd at	=	Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Lo	cation				_		10d. Inside City Limits
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	r 28	Director	MD Montgomery 10e. Street and Number	Montgom	ery Vill	Lage			10 011		L
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	ath w	Funeral	18667 Nathans Place 11. Marital Status 12. Was De	ecedent Ever in U.S. 13.	208 Was Decedent of		ain? (Cas	oifu Vee on No	Argen		
(0	or de	by F	Armed		f Yes, specify Cub					ace - Ame Iack, White	rican Indian, e, etc.
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ŏ	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at	Completed	15. Decedent's Education	16a, Dece	dent's Usual Occu	pation	Arge	IIIIII	16b. Kind of		
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Maryland	d be Menta	မ	Zoilo Duran			Obdu	ılia	Reus			
an	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stree	t and Numbe	er or Rural	Route Number,	City or Town,	, State, Zip	Code)
Σ	nd 2 saith n 27 er tra		Ingrid Duran/Wife	1866	7 Nathan	s Plac	ce M	ontgome	rv Vil	lage	MD 20886
ore.	of Heal of Heal fitem ?		20a. Method of Disposition	20b. Place of Dispo				ate	20c. Location	_	
Ĕ	Page nent o ant: If ury or		1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Metropoli	tan Crem	atory	8/5/	2010	Alexan	dria	, VA
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signiture of Juneral Service Licensee	22	. Name and Addr	ess of Facilit	y Mar	shall M	farch F	uner	al Home
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			234 Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on	it caused the death. Do not enter							Approximate
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<	uted Id	am	Cause (Disease or linjury that initiated events c.	te Renal Failu	re						2 weeks
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9	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d							\longrightarrow	
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Box	requires that the death certific been signed by the attending I should be detached for use as	Completed by Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pr 9 ☐ Unknown 9 ☐ Ur	egnant at time of death 5 - known	Other (specify) _					/lonth	Day Year
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Division of Vital Records,	lor A after Direct	Cel	4 Homicide determined buil	ding, etc. (Specify)	et, lactory, office			City or Town		per or Hur	al Route Number,
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	n 24 h	Medical	(Check 2 Medical Examiner: On the bounds only one) 3 Certifying Nurse Practione	asis of examination and/or invest	igation, in my opin	ion, death oc	curred at t	he time, date an	d place, and d	due to the c	ause(s) and manner stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	-	29b. Signature and title of certifier	7	29c. Licens				9d. Date sign		
			Sommen h	wen	010	124772	23		7/	31/20	010
			30. Name and address of person who completed ca	use of death (Item 23a) (Type, P					,	,	
			Sameer Kadri		CENTER I	ORIVE,	BET	HESDA, 1	MARYLA	ND 2	0892
	Stat			Registrar's Signature	0						
H	Registra	ir	AUG 0 6 2010	deser S. A	Parkel						

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amend #18 Per FH G906 8/17/2010 JH
State of Maryland / Department of Health and Mental Hygiene [] | []

mend #1 Per Phy G906 8/19/2010 Jh
Certificate of Death

Reg. No. amend #1 Per Phy G906 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 ď³ Whitfield Rudd 2010 $a^{\ M}$ 7:53 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore VA Medical Center Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) NC 1 X M 2 □ F Months Hours Min 5/2/1925 Director 231-22-4495 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20010 632 Keefer Place, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 If Yes, Give 1945 Year or Dates. 1946 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Worker Be 18. Mother's Name (First, Middle, Maiden Surname) **Susie** 17. Father's Name (First, Middle, Last) ည Lee Alpha Omega Rudd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20010 Gail Rudd Sanders/Daughter 632 Keefer Place, NW Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗍 Removal from State Harmony Memorial Park 8/11/2010 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligenses 22. Name and Address of Facility Marshall March Funeral Home C anet And 20011 4217 Ninth Street, NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Heart Attack (Myocardial Infarction) Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury July to for as a consequence of the attending physician and thed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of nas autopsy performed? Yes 2 No death? eral Director: After this certificate I filled in by the funeral director, page 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) ė: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred XXIatural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Certifica Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after within 24 hours a

To the Funeral E

completed filled ledical 29a Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) AU4176435I16616 08/03/2010

Registrar

State

David

31. Date filed (Month, Day, Year)

Ibrahimi

10 North Greene ST Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Donald Edward Russell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 24666 10-05807 Unk Unk 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day August 2, 2010 Medical Examiner 2333 hrs Donald Edward Russell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death White Way Rd & River Drive Road Edgemere **Baltimore County** 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year B. Date of Birth(MM/DD/YYYY If Under 24Hrs. **Funeral** Months Days Hours Min Director 215-82-0259 country) Maryland July 16, 1967 1 X M 2 F 43 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore 1 Yes 2 X No Edgemere permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6704 North Point Road 21219 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: _{Specify:} White ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 27 is marked other than 'unatic event, the Medical 21215-0036 Warehouse Labor 9 years 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Donald Russell Sr. Charlotte Hite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD Donald Russell Sr. Father 2509 Pac Lane, Edgemere Md. 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State August 7, 1 K Burial 2 Cremation 3 Removal from State crematory or other place) Cedar Hill Cemetery Baltimore, Maryland 4 Donation 5 Other Specify: 2010 Signature of Fune al Service Licen 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, 7110 Sollers Point Road, 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Physician Between Onset and /Medical Death Asphyxia Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of); (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last l or Attending Physician: The law requires that the death certificate be executed after death. and /sician/Medical AMENDED 23a,27,28a-f per me g906 8-16-10 vt X UNPENDED attending physician or use as the burial Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed? ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other Scene 1 V Yes No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural / Director: / 5 Pending 1 Yes 2 X No 11:07 pm 8-2-10 subject was asphyxiated Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) White Way Rd. and River Dr. Rd. Edgemere, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide (Specify) Park determined Funeral 4 X Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 3, 2010 completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

STATE OF THE WEAR PER PARTIE OF HEART AND WIENTAL Hygiene? 24667 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:46 AM Medical Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Memoria 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months $\Lambda^{Country)}$ Director item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location **Funeral Director** 1

Yes 2 □ No timor 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Never Married 2 Married Be Completed by Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) မ Informant's Name/Relationship (Type, Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other pla Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specify) 21. Signature of uneral Service Ucenser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Hypertension disease or condition Medical resulting in death) Due to (or as a consequence of) Ythins Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transil Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? completed filled in by the funeral director, page 2 should be detached for Year 4 Pregnant at time of death 9 Unknown Month Day 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 - Vilesol Hospital Other Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation after death Director: / Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) August 4, 2010 262960 nely 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Main Street Monson , MA 01057 <u>Peter Simmons Gre∉ne</u> Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner daeu -ee-If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Psy, Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🔀 Hours Director 3a or 28a-f shov be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 I No more 10g. Citizen of What Country? 23a c Funeral Examiner must items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Never Married 2 Married Black, White, etc. 5 Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than College (1-4 or 5+) Health and Mental Hygiene. Be 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route N 707 Laugh 20b. Place of Disposition (Name of cemetery, crematory or other) permit. Page 1 and Department of H 1 Burial 2 Kremation 3 Removal from State 5 Other (Specify) Signature of Juneral Service Licensee 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CERVICA NLER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-train that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be MELLITUS 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No POTHYROLDISM 1 ☐ Yes 2 ☐ No Yes 25. Was ca referred to medical Hospital or Attending Physician: Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other (Specify)} \) Hospital: 2 **N**o မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) る 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending Division 2 🗌 No Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of by knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 08/05/ State Registrar

K

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH 6906 8/11/2010 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24669 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 31, Day 2010 Year July 10:30 PM Garv Francis Sordy1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 😾 M 2 🗆 F Months Davs (Month, Day, Year) Jan. 15,1951 Hours Min. Director 215-84-4893 59 Ohio Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15210 Elkridge Way 20906 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) O Never Worked Be 18. Mother's Name (First, Middle, Maiden Surgame) 17. Father's Name (First, Middle, Last) 2 Francis Vincent Sordy1 Betty Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Harris / Mother 15210 Elkridge Way, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Demoval from State 8/4/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Signature of Funeral Service Lie 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ENCEPHALODATHY ANOXIC Physician/ 40145 Medical resulting in death) Due to (or as a consequence of): Examiner AIRWAY CBSTRUCTION UPPER 40145 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No signed by the 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEIZURE DISORPER Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available 24a. Was an has autopsy performed? Yes 2 No prior to completion of cause of death? After this certificate h 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗷 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury ✓ Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of hy mys, mo 023630 AUGUST 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANK J. MAYO MD 16220 FREDERICK RD #213 GAZTHERSBURG, MD 20877 J. MAYO, M. 32. Registra s Signal Color

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01ga Marie Siewicki August 2010 6:15a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brightview Assisted Living Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 86 Days Hours Min. 217-12-7536 **Director** Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 ☐ Yes 2X No Maryland Harford Whiteford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rms 23a or Funeral 2054 Susquehanna Hall Road 21160 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 🗌 Yes 2 🕱 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify:White 3 ✗ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Weigher & Packager Grocery Store Be Department of Health and Mental Hie Department of Health and Mental Himportant: If item 27 is marked other injury or other transceness. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Sofinowski Katie Brodowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2042 Susquehanna Hall Road, Whiteford, MD 21160 <u>Rudolph W. Siewicki, Son</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Metro Crematory, Inc. 8/5/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on with line. Interval Between Onset and Death Immediate Cause (Final Physician/ nemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner to for as a consequence of and that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🔼 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 X No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 🔀 No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Director: After this in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifie 45680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. N.R. Harapanahalli,

Registrar

DHMH 17 Rev 7/2009

State

602 South Atwood Road

AUG 0 6 201

31. Date filed (Month, Day, Year)

Maryland 21014

Bel Air,

#207,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010

			1 - State Registrar	ertificate of Death	Reg. No. 2010 24671					
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Robert Lee Selby		Date of Death 9018t 3, D2010 Year 12:54 p M					
	Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Center	4b. City, Town, or Location of Death Towson	4c. County of Death Baltimore					
	Funeral Director		5. Social Security Number 218−14−5515 6. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthday) 7. A	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. De	Date of Birth (Month Day, Year) C 23, 1922 Mary Tand					
	ryland 1-f show ied at	ctor	Usual Residence of Decedent 10a. State		10d. Inside City Limits 1 □ Yes 2 🖄 No					
	ith the Ma 23a or 28e st be notif	Funeral Director	10e. Street and Number 5312 Millfield Road	10f. Zip Code 21237	10g. Citizen of What Country?					
030	filed within 72 hours after death with the Maryland Hygiene. Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 🔣 No Specify:						
9500-61212	vithin 72 hou piene. er than "nat the Medica	Completed	Flementan/Seconday (0.12) College (1.4 or 5.) life.	edent's Usual Occupation be kind of work done during most of working DO NOT use retired) COUNTINE & Finance	16b. Kind of Business Industry Railroad					
Maryland	d be filed v Aental Hyg Irked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Carl R. Selby	18. Mother's Name (Fin	rst, Middle, Maiden Surname) R. Lee					
	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once <u>.</u>			ing Address (Street and Number or Rural Ro. 2 Millfield Rd., Bal						
_			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition cemetery, cre Dulaney	osition (Name of Date matory or other place) 8/7/1	, , , , , , , , , , , , , , , , , , , ,					
palt	permit. Departi Import any inj		MILITADI V. DAU	22. Name and Address of Facility Ruck 1050 York Rd., Towso	Towson Funeral Home, Inc.					
P	nysician/	56	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac or res	Approximate Interval Between Onset and Death					
-/	Medical Examiner	<u>.</u>	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	, of Head troums	3 23					
	cuted ind transit	xamine	Cause. Enter Underlying Cause (Disease or iinjury that initiated events	le crash some se						
00/0	tte be exe hysician a he burial-	dical E	resulting in death) Last Due to (or as a consequence of): d.		6 1 2 5					
. DOX 001	To the hospital or Attending Priysician: The law requires that the clearly certificate be executed within 24 hours after cleath. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year					
S, P.O	ulres triat u n signed by ild be deta	ρ	Pair II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pair I.							
records,	the law rey ate has bee bage 2 shou	Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
NI S	crari. ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only						
>	rnysi this c	2	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a, Date of Injury 28b, Time of		5 Residence 6 Other (Specify) hospice					
IO HOIS	ttenuming death. stor; After the fune	Certificate	1. Natural 5 Pending 2. Accident Investigation 3. Suicide 6 Could not be	work? 1 \(\superset \text{ Yes} \(2 \) \(\text{M} \) No	Describe how injury occurred W Struck by oncoming vehicle					
DIVISION	plual or nours after er all Direct lilled in by	sal Cer	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	400	Location (Street and Number or Rural Route Number, City or Town, State) LK RP AND GREENLOGERD, THEN IN					
1	ne rus in 24 hc he Fun ipleted	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death the control of the c	stigation, in my opinion, death occurred at the t death occurred at the time, date and place, an	time, date and place, and due to the cause(s) and manner stated.					
	with To t		29b. Signature and title of certifier	29c. License number 7 58303	29d. Date signed (Month, Day, Year) AVQV: F 3 20/0 Down SON MO					
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) N. Charles ST	DOWN MO					
	State Registra	-	31. Date filed Worth Day 2010 32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ralph Garwyn Sluder 2010^{Year} August 02 4:48 A. Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Summit Park Nursing Home Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 □ F Hours 11/21/1920 North Carolina 243-14-0203 90 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Arbutus 1 Yes 2 No 9 10e Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 5213 Arbutus Avenue 21227 USA 72 hours after death 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. "natural", or 1 TyYes 2 If Yes, Give ^{2 No'} 43-'46 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Janitorial Calvert Distillery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ed W. sluder permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o Stella Osborne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garwyn Sluder (Son) 5213 Arbutus Avenue Arbutus, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) Meadowridge Memorial Park 8/5/10 Elkridge, Maryland 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd. Elkridge, Maryland Washington Blvd, Elkridge, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or beart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) OCONCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause in the Uncertainty Cause (Disease or iinjury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the ! as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4- Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 No 1 🗌 Yes 2 🗌 No or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 De No Hospital Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4-Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation Director, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours and To the Funeral E Medical 29a, Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

Ba Himse

3455

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs.
Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 54 Maryland 216 68 6798 08/24/1955 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State show ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 XNo Director Anne Arundel Linthicum Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21090 U.S.A. 460 Susan Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒No 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. þ White 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Northrop Grumman Mechanical Draftman 2 years 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be Mental and Menta ו is marked Robert Parks Stevens Amy Grace Riley ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 460 Susan Court Darla M. Stevens / Wife Linthicum, Maryland 21090 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 07/30/2010 Elkridge, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 name 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardiac Arkes **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Hemorrhage Introventricular APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examines or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 10 3 Probably 4 Unknown 1 TYes certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 | IN 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2010 2 ER/Outpatient 3 DOA 6 Other (Specify) ည this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: : After t 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No death. 2 Accident 24 hours after death Funeral Director: Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ithin . 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

th, MD 32. Registrar's Signature 600 North Wolfe St, Baltimore, MD, 21287

L. Duckworth

Josh

31. Date filed (Month, Day, Year)

AUG 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ aŏÏó 6:20 PM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (enter Levindale Gewatur Baltimore WD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** , 1937 Months Hours 73 Pennsylvania Director 198-28-3566 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location with the Maryland traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Carroll MD Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 1148 Old Manchester Road 21157 USA items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?.

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ٥ Completed by 1 Never Married 2 🔀 Married Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa If Yes, Give 1 Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Edward W. Sypulski Stella B. Songaila 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1148 Old Manchester Road-Westminster, Maryland 21157 Virginia R. Sypulski-spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. St. Ignatius Cemetery Aug. 7, 2010 Pringle, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ankinson's disease Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, Examiner il any, leading to immediate cause. Enter Underlying Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) detached a \square Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 2 No 3 Probably 4 Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has page 2 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 24 hours after death.

Funeral Director: A 2 🗆 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier

Mosse CKNP Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Cletta Morse CRNP 2434 W. Belvedere Ave, Baltimore MO 225 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

AUG 0 6 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Robert Earl Stone Sr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death 10140 Bird River Road Middle River Social Security Number 7. Age (In yrs. last birthday, 76 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 🛛 M 2 🗆 F Months Days Hours (Month, Day, Ye Dec . 27 213-30-2812 Director 193 Usual Residence of Decedent show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10140 Bird River Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 🔀 Married Completed by Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore County College (1-4 or 5+) Elementary/Seconday (0-12) Bus Driver Public School 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Blanche M. Badders Ernest L. Stone Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Echo Trail Carroll Valley PA 17320 Lorraine Orlando /daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometers, crematory or other place)
Holly Hill Cemetery 8/7/10 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore MD 21. Sig ture unera Service Licer 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) m09 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical DIDIA Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did\tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2/1 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 [29c. License number 3 55 mpleted cause of death (Item, 23a) (Type, Print) 31. Date filed (Month. Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of M	1aryland		rtment of H	ealth and M	-		10	24676
Dii-i-		Registrar 1. Decedent's Name (First, Middle, Las			Cert	incate or D	eatri	2. Date of Dea	nth.		3. Time of Death
Physicia Medic Examin	al	Edith M. 4a. Facility Name (If not institution, give	Simp	SOII		4h City Town or	Location of Death	08		0 1 0 ty of Death	3:15 A M
Examin		9813 Caitlins Ct.				Ellicot	t City		Howa	rd	
Funeral Director		5. Social Security Number 6. Se 084-36-7047	9X □ M 2 X F	ge (In yrs. Ias 104	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birl (Month, Da 08/13/	h v, <i>Year</i>) 1905	g. Birth Cour	place (State or Foreign otry) Ohio
ind show at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				1.	10d. Inside City Limits
Maryls 28a-f)irect	Md. Howard		E1	licott						1 Yes 2 No
with the	Funeral Director	9813 Caitlins Cou	ırt			10f. Zip Code 21042			10g. Citizen of USA	f What Cou	ntry?
or items	by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 \(\sum \) Yes 2	2	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)		ace - Americ ack, White,	
2 hours after "natural", o	sted b	3	If Yes, Give Year or Dates.			☐ Yes 2 No			Specif		ite
ZID-	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		5+)	(Give k life, DC	NOT use retired)	ition uring most of worki	ng	16b. Kind of	_{Business In} maker	
Id ZI	Be	17. Father's Name (First, Middle, Last)	Z Irs.		House	wire	18. Mother's Name	e (First, Middle,			
ryiar uld be f unarked natic ev	잍	Elmer H. Miller	Ι		Laura B.						
id 2 sho alth and n 27 is r er traun		19a. Informant's Name/Relationship (Type, Print) Jay Simpson (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Statement of St									
nore age 1 an ant of He art: If iten y or oth		20a. Method of Disposition 1									
Desitiffinore, Maryliand Z I Z 13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specification of Fundamental Service Licenses)		All					-		Chapel PA
		23a. Part 1. Enter the disease, or comp								4.	Approximate
Pnysician/ Medical	9 9	shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Co	ron arm	Ath	croscleros	i				Interval Between Onset and Death Years
Examiner	L	Sequentially list conditions,	Due to (or as	a consequi	nce of):						
ted I Insit	amine	if any, leading to immediate Cause (Disease or iinjury	ence of):								
ate be executed hysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):						
ertificate boarding physic		IF FEMALE:	d								
atendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant :	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	/		1	ate of deliv	rery Day Year
at the ded by the etachec		1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								ntribute to t	he cause of death?
LIS, T	ed by	Primerary Hypertensia, Chronic Kidney Discose 1 1 Yes 2 No 3									
ecolus, law requires has been sig	Completed	,						24a. Was autop		prior to co death?	psy findings available ompletion of cause of
ian: The	Be Co	25. Was case referred to medical examiner?					ce of Death (Check	1 Tes		1 🗌 Yes	2 🗆 No
Physic Physic r this ce eral dire	၉	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of inju	ury 2	R/Outpatient 28b. Time of	3 DOA Othe	4 Nursing Ho		lence 6 Ot)
ttending death. tor: After the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	-		injury		res 2 🗌 No				
tal or A	al Cer	4 Homicide determined	28e. Place of Inj building, et	tc. (Specify)	ne, iarm, stre	et, factory, office		City or Tow		ber or Hura	I Route Number,
To the Hospital or Attending Physician: The law requires that the dealh certificate be executed within 24 hours fact death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached fir use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Certifying Nurse)	ner: On the basis of	examination	and/or investi	gation, in my opinior	n, death occurred at	the time, date a	nd place, and d	ue to the ca	ause(s) and manner stated.
To the Committee		29b. Signature and title of dertifier				29c. License	number 547/7		29d. Date sign	ed (Month, 2 / 20 / c	
10		30. Name and address of person who co	completed cause of o	death (Item 2	23a) (Type, Pr			k Mo		(- , -	
Stat Registra	e ir	31. Date filed (Month, Day, Year) AUG 0 6 2010	32. Registr	rar's Signatu	harle	,	Luthervill				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug Day 2010 Year Physician/ Jean Romaine Simpson 3 5:15A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster <u>Carroll</u> 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 1 🗆 M 2 🕱 F Hours (Month, Day, Ye 178-16-3425 89 Director PA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Marileal Evaning. 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster MD Carroll 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21157 Funeral 1415 Chazadale Way USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 1 Yes 2X No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: white 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Molly Myers Frank Smeltzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 1415 Chazadale Way, Westminster, MD Sharon Carlson-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Winfield, MD South Carroll Crem 8/4/10 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licensee Thomas V. 21157 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ≥ y 9 ☐ Unknown g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy 2 No 1 🗌 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) l a Hospital: Other: 4 Nursing Home 5 Residence 6X Other (Specify) Dove Howe 1 ☐ Yes 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate; 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation after death 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) Dam Waya, MD 51705

State Registrar

DHMH 17 Rev 7/2009

Westminster, MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. LANSIRIYA 349 Malwim

32. Registrar's Signature

ANSURIVA

31. Date filed (Month, Qay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:45 PM eges Medical Examiner unty of Death hday 9. Birthplace (State or Foreig 8. Date of Birth **Funeral** Sex 1 X M 2 Months Days Hours Min 78 Maryland 215 28 3280 Yrs. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore Baltimore 1 🗆 Yes 2 🏝 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3926 McDowell Lane 21227 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 Divorced Completed White er than "natur , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Baltimore City life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. sant: If item 27 is marked other tha ury or other traumatic event, the I 12th Fireman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernest Thompson Theresa (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3926 McDowell Lane Tracey Thompson / Daughter Baltimore, Maryland 21227 Important: If item 27 any injury or other the once. 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 08/09/2010 Baltimore, Maryland **Department** Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Loudon 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a conseq Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? be detached for 4 Pregnant at time of death Month Day Year Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier -Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 24679 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JULV 2010 Genevieve B. Talbott 8:35 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 2220 Uniontown Road Westminster 8. Date of Birth (Month, Day Year) Al 12 • 12,1942 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 M 2 XXF Mary Land 67 Director 215-40-5755 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at should be filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified Carroll Westminster Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 2220 Uniontown Road United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: "natural", White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) nd Mental Hygien Nursing Home Business Co-Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mattie V. Gover Rex George Cox of Health and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Carroll Talbott Husband 2220 Uniontown Road Westminster, MD Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State South Carroll Crematory July 23, 2010 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus of uneral Service License 22. Name and Address of Facility urrier-Queen Funeral Home unu ter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, g Immediate Cause (Final gulCerus Physiciani di eas condition res im g in death) Medical Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has been as the second of autopsy performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, F. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) State Registrar AUG 0 6 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2:45 PM **TAUBER** UGUST 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOS TAL OF BALTIMORE N/A BALTIMOS CITY 9. Birthplace (State or Foreign Country) BELGIUM If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Social Security Number 115-46-0274 Funeral Hours Min. 1 M 2 XF 0976374929 80 **Director** Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3601 CLARKS LANE, #201 21215 USA death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the HOMEMAKER OWN HOME Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be SCHREIBER **FENNA** TIMBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau GERALD TAUBER/SON 160 HARBOR VIEW, N. LAWRENCE, NEW YORK 11559 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ERETZ HACHAIM CEM. 08/04/2010 BETH SHEMESH, ISRAEL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MEUMOHIA DAYS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 X No Yes 2 N 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? within 24 hours after death. To the Funeral Director; After (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number Geros 000 mD AUGUST 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE BHAT (A) mD MAI HOS PITAL 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:40 PM August 4, Isabella Von Glatz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charlestown Retirement Community Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗙 F Months Days Min 82 Hours (Month, Day Year) New Jersey **Director** 143-22-6776 1927 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 United States 719 Maiden Choice Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates Specify. White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည John Malcolm Crider Maud Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Von Glatz /Husband 719 Maiden Choice Lane HR 318 Catonsville, MD 2122 20a. Method of Disposition 20b. Place of Disposition (Name of Aug 06 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Lie MO 1585 Kolobe 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pseuconsequence of): Ph sician/ weeks disease or condition Medical resulting in death) Examiner Bronchiceto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year been signed by the a should be detached f 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hours after death. neral Director: After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rry opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Choica

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>010</u> Ngoc-huong Thi Vo Month ам Physician/ 2:30 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Randallstown Season's Hospice 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Viet Nam **Funeral** Months Days Min onth, Day, Year) 1 □ M 2 🕱 F 67 Yrs Director N/AUsual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at **Funeral Director** Baltimore Yes 2 No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Viet Nam 21230 Washington Blvd. 1425 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Yes 2 No Yes, Give . Page 1 and 2 should be filed within 72 hours after irrent of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or jury or other traumatic event, the Medical Examii jury or other traumatic event, the Medical Examii þ 1 Never Married 2 Married Asian 1 ☐ Yes XXNo Specify. Baltimore, Maryland 21215-0036 Specify 3 - Widowed 4 M Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 9 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) unkn ည unkn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2213 Wilhelm Ave., Baltimore, MD 21237 Dao Vo / Ex-husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite 1 Burial 2 Cremation 3 Removal from State Woodbine, MD 8/6/2010 Final Journey Crem. 4 Donation 5 Other (Specify) injury 22. Name and Address of Facility
Maryland
PO Box 14 21. Signature of Funeral Service Licensee Dorota Marshall d Cremation Services 1413, Baltimore,MD 2 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line. Approximate interv Between Immediate Cause (Final Metastutu Pnysician/ disease or condition resulting in death) Medical r as a o nsequence of) Examiner Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery nse 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Day in the past 12 months?
1 Yes 2 No for Pregnant at time of death 9 Unknown been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate has I 2 🗌 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medica filled in by the funeral director, Be mateut examiner? Other: Hospita 4 Nursing Home 5 Residence 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature 2010 who completed cause of death (Item 23a) (Type, Print) 203 2835 MITH VITE 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 9,13 per fh g906 8-20-10 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Josefina 4:15 A M Baez Waterston August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) 1 □ M 2 🔯 F Months Hours Min. Director 74 347-30-8551 Dec. Usual Residence of Decedent or 28a-f show 10a. State 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 □ No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4715 Berkeley Terrace NW 20007 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Ecuadorian Equadorian Maryland 21215-0036 1 XYes 2 □ No Specify: Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) International Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Menes. Finance Institution <u>Librarian</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Chavez Luisa Carrera Alonso Baez Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4715 Berkeley Terr. NW, Washington D.C. John Waterston / Husband 20007 Baftimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2XXCremation 3 ☐ Removal from State Chesapeake Crematory 8/5/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service M00382 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of Examiner Aspiration Pneumonia Sequentially list conditions, it day a day cause. Enter Underlying Examine Dire to for as a consequence of that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes XX No 5 Other (specify) Month Day Year ed by the 1 ☐ Yes 2 9 ☐ Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۶ or Attending Physician: The law requires 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s performed? 1 Yes 2 No certificate Yes 2 X No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Division 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number Practices 13 to the state of the s 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wong

ndrew

31. Date filed (Month, Day, Year)

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8600 Old Georgetown Rd., Bethesda, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Aja Werkheiser		1- For State	State of M	aryland /		tment of		d Ment	al Hyg		2 0	10	21.681
Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, I Aja Ann Wer	, ,				Journ			Date of Dea Month	Day Year		3. Time of Death 0721 hrs
Å.		4a. Facility Name (if not inst 2 Haspert Road A	tution, give stree	t and number)			. City, Town, or			July 26, 2	4c. County of		
Funeral Director		5. Social Security Number 207–58–0320	6. Sex	1	(In yrs. Ias	st birthday)	If Under 1 Year Months Day	ar If Under	Min.		th(MM/DD/YYYY)	9. Birth	hplace (State or
апу		Usual Residence of Decede	nt			own or Location							10d. Inside City Limits
r death with the Maryland or items 23a or 28a-f show must be notified at once,	Director	Maryland Ba 10e. Street and Number 2 Haspert R	1timore	· · ·	Not	ttingha —————	10f. Zip Code	236		1	0g. Citizen of Wha	at Coun	1 Yes 2 X No
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urs after dea tural", or it	by Fun		Divorced If Yes, or Dat	Give Year es:	No No	1 Y	es 🏋 No		ind of work	done done	Specify: 1		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	mpleted	Elementary/Secondary (0		ollege (1-4 or 5-		during mos	t of working life imator				Allumi		
1215-0 d be filed w lental Hygid arked othe	Be Comp	17. Father's Name (First, Mic Charles We						Chery	yl Hi	11	Maiden Surname)		
and 2 should ealth and Me ealth and Me rem 27 is ma traumatic ev	의	19a. Informant's Name/Relat Christophe		int)	20b. Pla		pert Ro	ad Apt	K.,		nber, City or Town 1gham , Ma 1 20c. Location - G	ary1	and,21236
timore, t. Pages 1 ar thment of Hes rtant: If ites		1 Burial 2 XXCrem 4 Donation 5 Other	r Specify:	moval from Stat	e cre	ematory or other Lantic (rplace) Cremato:	ry	8/2/	2010	Glen Bu	ırni	e,Maryland
Baltii Departm Importa		21. Sign sure of funeral Ser	Saokar	us that caused the	ne death. D	7250	Washin	ngton such as ca	BIVd	L. KAU EIKI	ifman Fun idge,Md	218	175 Home, Inc.
/Medical Examiner		failure. List only one ca Immediate Cause (Final dise or condition resulting in deat	ase a. H	yperten (or as a consec		Cardio	ascula	r Dise	ease				Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca	U90	(or as a consec	uence of):								
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eath atte	Sicia	23b. Was decedent pregnant past 12 months? 1 ✓ Yes 2 No 9	10 10 1	Live birth Pregnant at til Unknown	me of deat	_ = =	death 3	Ectopic	pregnancy		Month	Da	ay Year
P.O. ss that the gned by the detach	2	Part II. Other significant co Intrauteri		_			lerlying cause o	given in Part	11.			_	ne cause of death?
Division of Vital Records, P.O. B spital or Attending Physician: The law requires that the dhours after death. Incral Director: After this certificate has been signed by the yfilled in by the funeral director, page 2 should be detached.	Completed									24a. Was a autop perfor 1 Yes	sy pri med? de		opsy findings available ompletion of cause of
Vital ysician:	e B B	25. Was case referred to me examiner? 1 Yes 2 No	Hospital	ı III inpaticin		R/Outpatient	B DOA	of Death (0	Nursing H	ome 5	Residence 6	,	Scene
Sion of Attending I death.	Certification:		Pending nvestigation	a. Date of Injury (Month, Day,Yea		8b. Time of Inju	1□\	ry at Work? Yes 2 1	No		now injury occurred		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,		4 Homicide	letermined (S	Be. Place of Inju					J	or Town, S	tate)		al Route Number, City
To the H within 24 To the F completel	edica	(Check only	Examiner: On the and m					, death occu			e(s) and manner a and place, and du	e to the	cause(s)
		Carol	Har	lan			O.C.I				July 26, 201		m, Day, Fear)
0			son who complet Assistant Me	dical Exami	ner 1	11 Penn Sti	eet, Baltime	ore, MD 2	21201				
Sta Registra	3.0	31. Date filed (Month, Day Ye	0 6 2010	32. Redistrars	Signature	A. Sa	West.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUG. 4, 3:40 AM **Physician** 2010 AUDREY E. WILSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A FUTURE CARE HOMEWOOD BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days) | Hours | Min. | DEC. 27, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 1 □ M 2√2 F MD. 220-12-8602 89 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location 1 Types 2 □ No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21218 1021 BONAPARTE AVE. UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: ≥ WHITE 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12TH College (1-4or 5+) SECRETARY STATIONARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT L. MILLER VIOLET A. MILLER ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNE TOOMEY/DAUGHTER-IN-LAW 145 BACK ST., APT. 106, WARDENSVILLE, WV 26851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 08/10/2010 GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signatur Lot Funeral Strvice Licenses 21224 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a. Part 1. Enter the disease, or ce shock, or heart failure. List of Meations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Corenovasular Due to (or as a consequence of): alendon Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lo as a consequence of Alline Schertix Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 🖒 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural

law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, death.

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Madical Examiner must be netitled all

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Physician

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Examiner

Maryland 21215-0036

Baltimore,

Hospital or Attending Physician: The n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in

within 2

Medical

State

29b. Signature and title of certifier

6 Could not be determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 6 . 10

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto 6821 fleisterstown DARSHAN. S. SALUIA

31. Date filed (Month, Day, Year)

2 Accident 3 Suicide

4 Homicide

29a. Certifier (Check only one)



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24686 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2^{ay} 2010^{ear} James R. Whitlock Sr. Aŭgüst 12:30 pm 4b. City, Town, or Location of Death Parkville 4a. Facility Name (If not institution, give street and number) 4c. County of Death
Baltimore 2012 Calvert Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) June 20, 1928 1 🛣 M 2 🗆 F Days Hours Min. 220-24-3833 82 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2012 Calvert Court 12. Was Decedent Ever in U.S. Armed Forces? 1∑(Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 Tyes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2yrs Elementary/Secondary (0-12) Steam Fitter 486 Local 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Scheffler John E. Whitlock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 Bowleys Quarters Road Balto. MD21220 /son James Whitlock Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State Bayview Crematory 8/4/10 Baltimore MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 300 Mace atruto 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiovascular disease resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? S/p partial colectory + chemotherap 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify)

Physician ' /Medical Examiner

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Certification: To

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "leading Exeminer must be notified at once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and a sector.) that initiated even resulting in death) Last

Examiner Physician/Medical

1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of Injury 28c. Injury at Work? 1 ☐Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

determined

29d. Date signed (Month, Day, Year) 2010

Blosha 31. Date filed (Month, Day, Year) State

Walther Blud Partville, MD 21234 Dixon 880C

Registrar DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician P^{M} 2010 Lillian D. Walton August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8810 Walther Blvd. Baltimore Parkville Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 □ M 2 👿 F Months Min. 80 Director 217-24-2825 06-02-1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 8810 Walther Blvd. #3116 21234 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Lillian D. Jones Joseph Michael Duffy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B<u>ridget D. Walton - Granddaughter</u> 33 Mallard Way Edgewood, Maryland 21040 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-07-2010 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Fameral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter in disease, or shock, or hand failure. Lis Immediate Cause (Final mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical a consequence of): cerotre Cauliovase disese **Examiner** thero SC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ DOVOL intermittet 1 S 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 5 ☐ Pending investigation 1 Vatural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

Registrar

31. Date filed (Month,-Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaven K. Gry MD 8800 Wather BIVA

32.

DOD 30972

8/4/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Month}}{\text{July}}$ Physician/ Dominic Antonelli Jr. .2010 Frank 19 10:00 AM Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9120 Harrington Drive Montgomery Potomac Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 XM 2 □ F ORTANoma Director 579-12-7525 88 14/08/1922 Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Montgomery Potomac 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20854 Funeral 9120 Harrington Drive United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 lpha Yes 2 $^{\square}$ No lpha Un lpha . Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Parking and permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate 12 Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Caroline Bernasconi Dominic Franklin Antonelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Gwenn Antonelli / Spouse 9120 Harrington Drive Potomac, MD 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemet. 7/26/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 M01276 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 Months Physician/ disease or condition Inanition Medical resulting in death) Due to (or as a consequence of): Examiner 3 Years Metastatic Prostate Cancer Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed 5 Years Prostate Cancer Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Veal Pregnant at time of death 2 No 9 Unknown detached g 🗌 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 K No Other: 4 Nursing Home 5 Testidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

o the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident completed filled in by the Suicide 3 ☐ Sulcide
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

James Alghren MD 2150 Pennsylvania Ave NW #1-100 Washington, DC 20037

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL

23 2010

12851

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 **Physician** 11:10 a_M John 21, Leo Burns July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Aug • 4°, 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 1 → M 2 → F 7. Age (In yrs. last birthday) **Funeral** Months Days Min Hours 171-22-5056 81 PADirector Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examinat must be notified at Fort Myers FLLee Director 1 ☐ Yes 217 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33908 USA 16471 Millstone Circle, Unit 103 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No White 9 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Electrical Construction Electrical Sales Manager Pages 1 and 2 should be filed went of Health and Mental Hyginnt: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Calhoun Robert A. Burns ည other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau 16471 Millstone Circle, Unit 103, Ft. Myers, FL Jean E. Burns/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State July 23 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sarcoma with Metastasis to Lung **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed the burial-transi and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð icate has been sig Peripheral Vascular Disease, Osteoarthritis, Spinal Stenosis 1 Tes X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2**X** No 1 □Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA this Certification: To 1 Inpatient 27. Manner of Death 1 K Natural 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Attending (Month, Day, Year) 5 ☐ Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Mary Ellen Ritchie,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

D61645

2901 Olney-Sandy Spring Road, Olney, MD 20832

July 22 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	aryland		rtificate of		and Me		giene Reg. N	010	24	690
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	/Medic Examin	cal	, , , , , ,	If not institution, give	e street and number)	rges	2.	4b. City, Town, o	r Location o	of Death		2 3 4c.	Sounty of De		pne
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	or 28	Director	10e. Street and Nur	mber				10f. Zip Code				10g. Citiz	zen of What	Country?	
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01	Physic this or	ျ	1 Yes 2					nt 3 DOA Oth	4 Ľ Nu				Other (S	pecify)	
ב	ding F	tion:	27. Mann of Deat 1 Natural	th 5 ☐ Pending investigation	28a. Date of Inju (Month, Da		Bb. Time of Injury	Wor	ryat k? Yes 2 ∐ l		d. Describe I	now injur	y occurred		
DIVISION	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director.	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	0	ury - At home c. <i>(Specify)</i>	e, farm, str	eet, factory, office	1163 2		f. Location (8 City or Tov		d Number or	Rural Route	Number,
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	To the within To the Complete	Me	29b. Signature and	title of certifier				29c. Licens	se number			29d. Dat	e signed (Me	onth, Day, Ye	ear)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month DENNIS LEE BEALL 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death La Plata Medical Charles Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 3 Month, Pan 5eat 9. Birthplace (State or Foreign WASH D.C. 5. Social Security Number 7. Age (In yrs, last birthday) Months Days 577-76-8579 56 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 X No MD. CHARLES COBB ISLAND 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 17520 ORIOLE DRIVE 20625 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No ARMY If Yes, Give 1 9 71 − 74 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2▼ No Specify: SpecifWHITE 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSE PAINTER SELF EMPLOYED 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLIFFORD ALLEN BEALL, SR. CARLYN ELIZABETH HASKINS 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) $1\,7\,5\,2\,0\,$ ORIOLE DR. COBB ISLAND, MD. 20 19a. Informant's Name/Relationship (Type. Print)
GARY S. BEALL-BROTHER COBB ISLAND, MD. 20625 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition □ Burial 2 X Cremation 3 □ Removal from State
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□ Burial 2 X Cremation 3 □ Removal from State
□ Burial 2 X Cremation 5 □ 22 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. T.A PLATA, MD. 20646 M00479 21. Signature of Funeral Service Licensee Une Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that corned the shock, or heart failure. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Multisystem Nachs disease or condition resulting in death) Due to (or as a consequence of): coholic Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

hours after death with

Director

Funeral

Completed

Be

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, the Machail Examiner is and the motified at

Health and Mental Hygiene.

permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.

Baltimore,

Physician/Medical

2

Completed

Be (

Certification:

Medical

and burial-trar attending physician for use as the burial signed by the a d be detached for cate has been signated by page 2 should b certificate To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director, p

law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

Part | Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24a. Was an autopsy performed? Yes 2 100 1 ☐Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation

6 ☐ Could not be

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

Natural 2 ☐ Accident

3 Suicide

4 - Homicide

🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatu

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

lene

31. Date filed (Month, Day,

32. Registra

State Registrar

DHMH 17 Rev 1/2001

10-05353 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Christopher Robert Barry State of Maryland / Department of Health and Mental Hygiene 2010 24692 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day July 17, 2010 **Medical Examiner** 2257 hrs Christopher Robert Barry 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 6451 Middleburg Road Keymor Carroll 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Age (In yrs. last birthday) Hours Director 39 216-15-8692 1 M 2 F Nov. 5,1970 Country)Maryland Yrs Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits 1 Yes 2 No s 23a or 28a-f show e notified at once, 28a-f shov Frederick Union Bridge death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13111 Good Intent Rd. 21791 U.S.AFuneral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes è Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural",
injury or other traumatic event, the Medical Examiner. 3 Widowed 4 v Divorced If Yes, Give Year White 1 Yes 2 No specify: Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Driver Truck 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be John R. Barry Catherine A. Vondermse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Barry (Brother) 108Boundary Ave. Apt.17 Thurmont, Md. 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Aug. 6, Smithsburg Crematory Smithsburg, Md. Donation 5 Other Specify: 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md AVIS 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line Between Onset and /Medical Death Cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): rand transi The law requires that the death certificate be executed Sa X UNPENDED AMENDED 23a, 27, 28a-f, per ME g906 8/18/10 TT attending physician for use as the burial -Physician/Medi Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Year Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other Scene After this ER/Outpatient 3 1 🗸 Yes DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification 1 Natural 1 Yes 2 X No 5 Pending the 7/17/10 Fd 10:43 p**n** 2 ___ Accident Investigation 28f. Location (Street and Number of Rural-Route Number Rivers Rural-Route Number Rura 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire 3 Suicide 6 X Could not be Keyhior, State determined residence the Hospital 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 18, 2010

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

31. Date filed (Month, Day,

OCME

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Mo}Jth 29, 2010 Physician/ 9:50 PMM Butler Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany 98 LaVale Blvd. LaVale If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Hours Min. 1 🖳 M 2 🗆 F Oct 18 723-14-7035 Director 81 Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director LaVale MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 98 LaVale Blvd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married ģ 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 🗌 Widowed 4 🗎 Divorced Korea white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) disabled n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ben Butler Lucy (Snyder) Helbig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98 LaVale Blvd. LaVale MD 21502 Annabelle Butler wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 8/2/2010 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Surv 22. Name and Address of Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LYMPHOMA - WIDESPREAD Physician/ CELL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a nonsequence of) Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 L Yes **Division of Vital** Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral L Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one)

State Registrar 29b. Signature an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A-MOEN

MA

32. Regist ar's Signature

D0033717 (MANYLANS

(068 NOTRONA (PROWNY LAVARE, MINISTERN Z() DE

JULY 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Ermine Cherney Medical July 19,2010 9:45 P. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fairland Nursing and Rehabilitation Center Silver Spring Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 12, 1 - M 2 - F 9. Birthplace (State or Foreign Director 215-01-9524 Hours 92 Maryland <u>. 1917</u> Usual Residence of Decedent han "natural", or items 23a or 28a-f show Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State Director 10b. County 10c. City, Town or Location MD 10d. Inside City Limits Howard Ellicott City 1X Yes 2 No 10e. Street and Number 10f. Zip Code Funeral 10113 LaBelle Ct. 10g. Citizen of What Country? 21042 United States 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No Yes, Give Black, White, etc. 3 Widowed 4 Divorced Completed 1 ☐ Yes 2 No Specify. Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit, Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12 Homemaker Be Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Wolk Esther Schweitzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Owen Cherney/Son 10113 LaBelle Ct., Ellicott City,MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place George Washington University Med. Cei 1 🔲 Burial 2 🗀 Cremation 3 🗀 Removal from State 20c. Location - City or Town, State 4 Donation 5 Other (Specify) July 20 Washington, D.C. Center 2010 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. Just 2 sands /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician/ Interval Between disease or condition resulting in death) Congestive Heart Failure Medical Onset and Death Due to (or as a consequence of) **Examiner** Peripheral Vascular Disease Sequentially list conditions, if any leading to he neciate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last 4 Years Examiner Due to (or as a consequence of): that the death certificate be executed resulting in death) Last attending physician a for use as the burial-Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 3 Cther (specify) ed by the a Pregnant at time of death Month Year Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? Records, cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 Munknown certificate has 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 2 XN æ 1 Tes 26. Place of Death (Check only one) 2 🔀 No 1 Yes within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 X Natural 28d. Describe how injury occurred 5 Pending injury Accident Investigation 1 Yes 2 No Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) R151747 July 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road Suite 130 Rockville, MD 20898 Nkiru Ezeani, CRNP 31. Date filed (Month, Day, Year, State Registrar's Signature Garles

Registrar DHMH 17 Rev 7/2009 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Cain July 22. ^D2010 Sr. 8:40 Leigh P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** .6831 Holly Way Prince George's Accokeek Sex 1^X M 2 □ F If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours 0992491962 Marwland 213-84-0136 **Director** 47 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗌 Yes 2 🕱 No Accokeek Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20607 Funeral items 23a USA 16831 Holly Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian Armed Forces?
1 Yes 2 X No Black, White, etc. ò þ 1 Never Married 2 X Married hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Truck Driver <u>12 ye</u>ars other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Christina Ronner Frederick Albert Sr. Cain permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16831 Holly Way Accokeek, Maryland Wife Cain Kim 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Kalas Crematory Edgewater, Maryland 7/24/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A 21. Signature of uneral Service Licensee m 1. lach 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ **EMPHYSEMA** disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit Exam that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 1 No page death? After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 2 **N** No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completed filled in by the funera 28d. Describe how injury occurred Certificate: 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

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Katalin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Roth

MD 030936

3720 Upton Street N.W. Washington, D.C.

7/23/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Justin Capretti 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham 5. Social Security Numbe If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-36-8173 1 XM 2 □ F 70 Hours Min. Jan. 13, 1940 Washington, DC **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Prince George's Maryland Lanham 1 Ves 24 No 10f. Zip Code 20706 10g. Citizen of What Country? United States 10e, Street and Number è "natural", or items 23a or 6219 93rd Avenue Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Xyes 2 No
If Yes, Give 10 Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1959–1963 Year or Dates. 1 ☐ Yes 2 ▼No Specify: Specify: White Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) Pipe Fitter NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Doris Ellen Shields Sunday Capretti Important: If item 27 is marke any injury or other traumatic once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan R. Capretti -wife 6219 93rd Avenue Lanham, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 8/2/2010 Alexandria, Virginia Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate l 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) cami fer? Yes 2 🗌 No မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination alroys investigation, in my opinion, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 0 who completed cause of death (Item 23a) (Type, Print) Good Luck 20. Lanham 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State

Registrar

Donald

Registrars Signature

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State Registrar

DHMH 17 Rev 1/2001

CRNP

Name and address of person who completed cause of death (Item 23a) (Type, Print)

onwordin

Registrar's Signature

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31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 24698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20^{Year}0 John Joseph Costa 7:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 13116 Fountain Head Road Hagerstown Washington . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yo Country)
New Jersey 1 **X** M 2 □ F Months Days Hours Min **Director** 142-14-0119 87 Nov. Usual Residence of Decedent show or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No MD Washington Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 13116 Fountain Head Road 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 X Yes If Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Automotive life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Vice President Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of raumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. 2 Samuel S. Costa Mary V. O'Rourke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katy Costa-Sweeney/Daughter 813 View St., Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 7/30/2010 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mark 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ORONARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Wunknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy
performed?

Yes 2 No After this certificate 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 임 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

botham

32. Registrar's Signature

29c. License number

25399

Campus

21742

2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** JULY 30, Clifton Leo Delauney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boonsboro Reeder's Memorial Home If Under 1 Year If Under 24 Hrs. Month, Days Hours Min. (Month, Day, Year) Nov. 26, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1√ M 2 F 89 Director 215-14-2599 Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examinar must be notified at Director Sharpsburg Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 21782 191 N. Hall St. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

LATTYPES 2□No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 42 - 461 □Yes 2 No Specify: \$ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Concrete Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, II once. 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Elinora V. Grove ပ Aaron B. Delauney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 433 Sharpsburg, Md. 21782 Betty L. Curley (Friend) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' Aug. 2 Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg Md. 21783 Low Tan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CARCINGMA PROSTATE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) death certificate be executed ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of). Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for 5 ☐ Other (specify) signed by the a o 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by DYSPHACIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an page 2 certificate 2 4 1 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 10 Natural

__Pease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2010

U.S.A

Black, White, etc.

Washington

9. Birthplace (State or Foreign Country) Mary Land

White

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

Month

Year

10d. Inside City Limits

1 √Yes 2 No

11:15A.M

1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -all mo D18019 JULY 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. VASANT DATTA. 340 MILL STREET, HAGERSTOWN, MARYLAND 21740

1. Date filed (Month, Day, Year) | 32. Registrar's Signature 301-739-7100 State Registrar **ORIGINAL**

10-05771 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 24700 Richard Dixon State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death **Medical Examiner** 1235 hrs Richard Allen Dixon August 1, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Director Country) MD 1 X M 2 F 213-64-5865 56 02/18/1954 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ij 1 Y Yes 2 No 28a-f show Frederick Frederick with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 S. Jefferson St. 21701 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: Specify: white à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry permit Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is more Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9 bricklayer masonry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin E. Dixon, Sr. Mary Virginia Hahn 19a. Informant's Name/Relationship (Type, Print) မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Dixon / wife 119 S. Jefferson St., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 08/03/2010 Smithsburg Crematory Smithsburg, 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Pastord Funeral Rome MO1222 106 E. Church St., Frederick, MD 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed physician and the burial - trans Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ⋧ σ. 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No death? 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Other Nursing Home 5 Residence 6 Other this 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 V Natural Division 1 Yes 2 No 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 2, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar

31. Date filed (Month, Day, Year) 1 R 2

arke

32 Registrar's Signature

ENECLA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 24701 10-04814 Dennis Brian Lee Doss 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month 0845 hrs Medical Examiner June 27, 2010 Dennis Brian Lee Doss

4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death -Walder Waldorf Charles 10395 Chateau Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Wash. D.C Days Hours Min Director 1 X M 2 F 29 Nov. 20, 1980 220-17-8622 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 1 X Y Yes 2 No s 23a or 28a-f show notified at once. Maryland Charles Waldorf hours after death with the Maryland Director 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number <u> 20601</u> 10305 Janice Place Funeral 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X X No Yes f Yes, Give Year or Dates: 1 Yes 2 X No specify: White 3 Widowed 4 Divorced Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n
injury or other traumatit event, the Medical E Baltimore, MD 21215-0036 Local 602 Building Engineer 12th. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sherry Lorraine June Poole Dennis Lee Doss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ္ <u>Sherry Doss/ Mother</u> <u> 10305 Janice Place, Waldarf, MD.</u> 20601 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State July 1, 2010 Waldorf, MD. Trinity Mem. Gardens Donation 5 Other Specify 22. Name and Address of Facility Huntt Funeral Home Signature of Funeral Sirvice Light 3035 Old Washington Rd. Waldorf, MD. 20601 Part Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death Immediate Cause (Final disease a.Oxycodone and alcohol intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED attending physician for use as the burial AMENDED 28a-f, per ME g906 8/18/10 TT 23a,27 The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? page Yes 2 No 1 🗸 Yes 2 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural unk 1 Yes 2X No Director: d in by the f 5 Pending Fd 6/27/10 Fd 6:30 am Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10395 Chateau Dr Waldort, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide (Specify) Found: private dwelling Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number June 28, 2010 O.C.M.E.

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

00315

Laron Locke MD

31. Date filed (Monthe Day He

OCME

Name and address of person who completed cause of death (Item 23a)

620

Assistant Medical Examiner

32. Registrar's Signature

Known

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Beston

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24702

State of Maryland / Department of Health and Mantal Union

	•	State Amend Item 23art1,25 Per me, g906,0870672010dhb Certificate of Death		Re	g. No.	
Dhysicia	·- /	1. Decedent's Name (First, Middle, Last)	2. Dat Mo	te of Death	Day Year	3. Time of Death
Physicia Medio		Barbara Estelle Faulkner	Ju	NE	19 2010	1323 м
Examin	er	4a. Facility Name (if not institution, give street and number) Southern Maryalnd Hospital Clinton	Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 1 \square M 2 \square F 7. Age (In yrs. last birthday) 1 \square M onths Days Hours 1 \square Months Days 2	Min. (Mo	e of Birth onth, Day, Y	(ear) Cou	nplace (State or Foreign ntry)
D W	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		, ,	1702 110.	10d. Inside City Limits
arylan a-f sh fied a	ecto	MD PG Upper Marlboro				1 ☑ Yes 2 ☐ No
he Ma or 28	Dire	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Cou	untry?
with t s 23a uust be	Funeral Director	14403 Crooms Airport Road 20772			USA	
death ri tem ner n		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P	n? (Specify Yes Puerto Rican, e	or No- etc.)	14. Race - Amer Black, White	
DEBILITIOFE, IMBRYIBING Z1Z13-UU3O permit. Paye 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.			Specify:Blac	
1 D-1	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	f working	1	6b. Kind of Business I	ndustry
vithin giene.		Elementary/Seconday (0-12) 12th College (1-4 or 5+) Security Officer			Private	
filed valued of other seent,) Be	17. Father's Name (First, Middle, Last) 18. Mother's	s Name (First,	Middle, Ma	niden Surname)	
Yland Ild be filed Mental Hy narked ott	မ		rnett			
Mar 2 shou th and 27 is n traum	3 8	19a. Informant's Name/Relationship (Type, Print) Laisha Armstead/ Daughter 313 Livingston T			Eity or Town, State, Zip Apt WDC 20	
I and I Healf		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		Oc. Location - City or	
Salttif lor bermit. Paye 1 Department of Important If if any injury or o		1 ★ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ponation 5 Other (Specify) Harmony Mem. Pk. 0				
permit Depar Impor any in		21. Signature of Fune all Survice Library 22. Name and Address of Facility 4594 Beech Rd				rvices MD 20748_
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	rdiac or respira	atory arrest	t,	Approximate Interval Between
Physician/		Immediate Clause (Final disease or condition resulting in death) a. LARGE TOTRACERSBRAL H	EMORI	ZHAG	<u>ا</u>	Onset and Death
Examiner		Due to (or as a consequence of): Hypertensic	on.			
d sit	Examiner	Sequentially list conditions, Due to (or as a consequence of it.)		11		
± _ €	xan	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	<i>n</i> /1-1	ALC: N. E.	MALNINER	
and and	ш					
be execu sician and burial-tra	ical E	a strong	APPROVE BY			
ficate be executed g physician and as the burial-transit	Medical	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.	LAPPROVE BY			
X 66 / 00 th certificate be executed the certificate and the desiral and the certificate as the burial-trans.	Medical	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy	APPROVE BY		23d. Date of deli	
be death certificate be executed that the attending physician and sched for use as the burial-tra	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	APPROVE BY			very Day Year
y F.C. BOX 86/00 se that the death certificate be execu- igned by the attending physician and be detached for use as the burial-tra	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		e. Did toba	23d. Date of deli Month	Day Year the cause of death?
requires that the death certificate be execurequires that the death certificate be execuseen signed by the attending physician and should be detached for use as the burial-tra	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	23	e. Did toba 1 □ Yes	23d. Date of deli Month acco use contribute to	Day Year the cause of death?
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can: The law requires that the death certificate be execucian: The law requires that the death certificate be execusertificate has been signed by the attending physician and actor, page 2 should be detached for use as the burial-tra	Be Completed by Physician/Medical	23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	23	e. Did toba 1 Yes a. Was an autopsy performe Yes 2	23d. Date of deli Month acco use contribute to 2 No 3 Pr 24b. Were aut prior to c death?	the cause of death? obably 4 Unknown opsy findings available ompletion of cause of
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of Vical necology, F.O. box 90, g Physician: The law requires that the death certific ter this certificate has been signed by the attending neral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	Second pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1 Natural 1 Natural 5 Pending 28a. Date of injury 28b. Time of injury 28b.	23 24 (Check only or ing Home 5 [28d. De o 28f. Loc Cit) ace, and due to turred at the time	e. Did toba 1 Yes a. Was an autopsy perform Yes 2 ne) Residen Scribe how cation (Strey or Town, 1) to the cause e, date and due to the ca	23d. Date of deli Month 23d. Date of deli Month 24b. Were aut prior to c death? 1 Yes 24b. Were aut prior to c death? 1 Yes 24b. Were aut prior to c death? 1 Yes 24b. Were aut prior to c death? 1 Yes 24b. Were aut prior to c death? 1 Yes 24b. Were aut prior to c death? 1 Yes 24b. Were aut prior to c death? 1 Yes 24b. Were aut prior to c death? 1 Yes 24b. Were aut prior to c death? 1 He was a c death. 1 He was a c	the cause of death? obably 4 Unknown opsy findings available ompletion of cause of 2 No No al Route Number, ted. ause(s) and manner stated. stated. Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ayona Kahnae July 2010 6:00 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Unde 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 □ M 2 🔀 F Months Hours Min. 219-87-7363 Director June 11, 2010 Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene.
Important: If flew 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Modest Exp. inc.; ust be notified any injury or other traumatic event, its Modest Exp. inc.; ust be notified. 1 X Yes 2 □ No Director Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20737 Apt.# 514 5600 54th Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. **Black** \$ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenny Ford Danyelle Foxx ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Karen Court Apt. #202 Laurel, Maryland 20707 Tracy Lewis/ Grandmother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date July 21, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Lee's Crematory Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility 21. Signature of Funeral Service Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC or complications that caused the death. Do not enjer the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the shock or heart failure. List only one call e on each me. Immediate Cause (Final **Physician** /Medical Due o or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) 1 ∐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 | Yes 2 1 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No Division of Vital 1 Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

State Registrar 29a, Certifier

(Check only one)

and title of certifie

30. Name and address of person who completed

(Month, Day, Year)

DHMH 17 Rev 1/2001

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ju^{Month} 20, 2010 12:45 PM Edward FORMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Hebrew Home of Greater Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Aug. 28, Yea 1920 Newntryork 89 Director 129-10-5819 ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington DC 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20007 United States 3916 Highwood Court, NW 12. Was Decedent Ever in U.S. Armed Forces? 1 IÀ Yes 2 □ No If Yes, Give Year or Dates.42-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. white Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 Widowed 4 X Divorced permit. Page 1 and 2 should be filled within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Real Estate and College (1-4 or 5+) 5+ Elementary/Seconday (0-12) General Law Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sarah (unknown) Max Forman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3916 Highwood Court, NW, Washington, DC 20007 Sallie Forman, Former Wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Arlington National Cemetery 11/04/10 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Q Other (Specify) Arlington, VA ቸንትሮከተከሄዚያ፣ ዝጅቻቸew Funeral Home <u> 254 Carroll St., NW. Washington, DC</u> 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a physician and the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last or Attending Physician: The law requires that the death certificate be exer Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached g | | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy this certificate 1 Yes 2 No Yes 2 No **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 12 No Hospital Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 10+1 069568 07/20/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 montose Rd, Rockville, mD 20852 A-Chilakamarn

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Shirley Fogle Page July 20, 2010 1:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Renaissance Gardens at Riderwood Village 8. Date of Birth (Month, Day, Year) Aug. 13, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🛛 F North Dakota 29 Director 469-18-4374 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show If o Modical Examiner must be notified at Maryland P.G. Silver Spring 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20904 3160 Gracefield Road, #1105 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2x No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Marcus Newton Miller Lydia Saphrona Pagenhart traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau Linda Blair/Daughter 24109 Bush Hill Road, Gaithersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2010 Rockville, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service License ndaso 1101503 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1 Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Malignant Ascites /Medical Due to (or as a consequence of): Examiner Adenocarcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): P.O. Box 68760, physician The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 5 Other (specify) 1 □Yes 2 XXXIIo detached 9 Unknown ģ ed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 sign I be Coronary Artery Disease, Diabetes Mellitus, Type II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform meu 2⊠No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P⊠-Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) X Nurse Practificated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 R158667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3160 Gracefield Road, Silver Spring, MD 20904

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL

23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland 1 - State Registrar		artment of H <i>tificate of L</i>			2010	24706
	Physicia		Decedent's Name (First, Middle, Last) Matthew Gardner				2. Date of Death Month July	Day Year 10, 2010	3. Time of Death 8:30 P ^M
,	/Medic Examin		4a. Facility Name (If not institution, give street and number)	-	•	Location of Death		4c. County of Deatl	1
Z			St. Thomas More Medicial Comple		Hy If Under 1 Year	rattsvill			George's
	Funeral Director		5. Social Security Number 240–40–8289 6. Sex 1 △ M 2 □ F 7. Age (In yrs. In part of the part of th	est birthday) Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day) Sept. 29,	(ear) 933 Sou	th Carolina
	pug M	-	Usual Residence of Decedent 10b. County 10c. City	, Town or Lo	cation				10d. Inside City Limits
	f sho	20	Maryland Prince George's		Д	istrict H	leights		1 X Yes 2 □ No
	r 28a-	irec	10e. Street and Number		10f. Zip Code	1001100		g. Citizen of What Co	untry?
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020	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. ie marked other than "natural", or iteme 23a or 28a-f ehow aumatic event, the Medical Examinational is motified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 ☎No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecfy Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B1	
2-00 <i>3</i>	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ing 16	6b. Kind of Business/	Industry
Z	vithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life.				Daniero	
7 2	illed w Hygier ther ti	Co	8th 17. Father's Name (First, Middle, Last)		Cons	truction 18. Mother's Nam	e (First, Middle, Ma	Priva aiden Sumame)	ice
yland	id be in the lid be ked o	To Be	Isiah Gardner			01	lie Clyb	urn	
	shoul ind M marl	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State, 2	Zip Code)
, Na	s 1 and 2 should Health and Mer Item 27 ie marke other traumatic		Angila L. Fouch/ Daughter	All the state of t	La Company of the Com				, Md. 20747
ore	or oth				sition (Name of matory or other place		7 23	Oc. Location - City or	
бантто	it. Pag rtmen rtant: njury	- 21	4 Donation 5 Other (Specify) 21. Signature of Funeral Pervice Coenses		Cremator		0	Clinton, N eral Home,	
a a	permit. Pages 1 and 2 Depertment of Health a Importent: If Item 27 is any injury or other tra-		raull is and	\$ 1140	001 Benni	ng Road N	E Washi	ngton, DC	20019
			23a. Part Poter the disease, or complications that caused the death shock of heart failure. List only one cause on each line. Immediate Cause (Final					st,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Arteroscelo Due to (or as a consequence of the condition		Cardio Va	scular Di	.sease		
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	icate be executed physicien and s the burial-transit	dical Examin	fl. air., leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the co	uence of):					
8/60,	e be ex	calE	d.						
0		0	TE FEMALE.					1	
C. EOX	ires that the death certifi signed by the attending d be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of decent in the past 12 months 2 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Fetal 4 □ Pregnant at time of decent in the past 12 □ Fetal 4 □ Fet	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
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rds,	w requires been sign should be	ed by					1 □ Yes	s 2 □ No 3 □ Pi	robably 4 💆 Unknown
Kecord		Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
	sicien: The law certificate hes l irector, page 2 t	e Co	25. Was case relerred to medical			OC Place of Dec	1 Yes 2 th (Check only one		2 □ No
Vital	Physician: this certific ral director,	0 0	examiner?	ER/Outpatie	nt 3 DOA Oth	Or:		nce 6 □Other (Spe	ecify)
on of	ding h. After fune	tion: T	27. Manner of Death 1 ∑Natural 5 ☐ Pending 2 ☐ Accident investigation	28b. Time of Injury	f 28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe how	w injury occurred	
Division	al or Attending safter death. i Director: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	Hospital or 24 hours afte Funeral Dir letely filled in I	edical (29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my kno 2 ★ Medical Examiner: On the basis of examinal and manner stated.						
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier		29c. Licens		_	d. Date signed (Mon	
)	2		Bullen live	n	De	255	J	uly 20, 2	010
	20		30. Name and address of person who completed cause of death (Item	23a) (Type, 428		eluz. 12	1 Huat	built 1	MD50281
	Sta		31. Date filebut Month, Bay 2010 32. Registrar's Signa	ture	1	-9-7	, , ,	-1 - 1 - 1	
	Registi	ar	Lewell B.	型なしたシ					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24707 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:20 P M July 27, 2010 Geneva M. Graf 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Goodwill Mennonite Home Grantsville Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days 1 ☐ M 2 🛛 F 212-01-1684 92 July 14, 1918 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Garrett Accident 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21520 USA 480 Cove Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 K Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Schlesinger Henry Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 480 Cove Rd., Accident, MD Linda G. Shane/Daughter 21520 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Country Side Crematory July 29, 2010 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service No. P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final DNEUMONIA disease or condition resulting in death) Due to (r as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be rediffed at once.

Baltimore, Maryland 21215-0036

Examine burial-trar attending physician for use as the buria Physician/Medical signed by the a <u>á</u> Completed Be Certification: To after death Director: d in by the t ר 24 hours aft ie Funerat Di oletely filled ir

2

2

27

29b. Signature

Medical

12

the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	d.								+	
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 3 No 9 □ Unknown	23	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3 Ectopic					23d. Date of Month	delivery Day	Year
nt ii. Other significant condition	ions contr	ibuting to death but not res Liabet	ulting in the underlying	caus	e given in Part I.		23e. Did tobacco	12		se of death?
							24a. Was an autopsy performed? 1 ☐ Yes 2	prior death	autopsy fine to completion? es 2 N	dings available on of cause of
5. Was case referred to medica					26. Place of De	ath (C	Check only one)			
examiner? 1 ☐ Yes 2 No	Ho	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 I	DOA	Othor: 1		5 ☐ Residence	6 ☐ Other (S	Specify)	
7. Manner of Death 1 Natural 5 Pendir 2 Accident investi	ng gation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c.	Injury at Work? 1 □ Yes 2 □ No	280	d. Describe how inj	ury occurred		
3 Suicide 6 Could 4 Homicide determ		28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, of	fice	28f	Location (Street City or Town, Sta	and Number or ite)	Rural Route	e Number,
9a. Certifier (Check only one) Certifying Medical	ng Physi Examin	cian: To the best of my known; On the basis of examination and manner stated.	owledge, death occurrention and/or investigati	ed at on, in	the time, date and place my opinion, death occ	e, and	d due to the cause at the time, date a	(s) and manne ind place, and	r as stated. due to the ca	ause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

within 24 ho

To the Fune

completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 Day Physician/ 127PM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Park montgomer Washington lakoma 9. Birtiplace (State or Fore 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. Month, Hours Day, Country) Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral permit Page 1 and 2 should be flied within 72 hours after death with Department of Health and Mental Hygiene. Important if item 27 is marked other than ".... any injury or other traumaii... 23a 207 U5. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married δ 1 ☐ Yes 🕮 Mo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 2+1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Roule Number, City or Town, State, Zip Code) 1013 Huntsworth Ct Capitaliteights itenriena Thomp mD dau9 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fungral Service Licensee 22. Name and Address Bianchi 812 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciati disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, frany, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The to for as a consectation of the Exam as the burial-transil a and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy death? 1 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes ♣ No Be 26. Place of Death (Check only one) Hospital: ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\text{Yes} \) 2 \(\text{No} \) Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ave Takoma Park, MD Chirumamilla Paima 7600 OVVOIL Registrar's Signatur State Registrar

Physicia: Medic Examin Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar			of Maryla	•		nt of H te of D			1ental Hy		20	10	24709
Physician Medica		1. Decedent's Name		ast) slie Ann	Hand						2. Date of De Month July	eath 21	^{ay} 2010	Year	3. Time of Death 1205 A M
Examine	r	4a. Facility Name (if n Casey Hous 5. Social Security Nur	se, Mont		County		e Ro	y, Town, or ckvil er 1 Year	1e			40	c. County	of Death	ery
Funeral Director		578-94-36	604	1 ☐ M 2 ■ F	7. Age (<i>In yr</i> s. 51	Yrs.	Months		Hours	er 24 Hrs. Min.	8. Date of Bi		958		nplace (State or Foreign Lington, DC
8a-f show tified at	ctor	Usual Residence of D 10a. State Maryland	Decedent 10b. County Montgon	merv		ity,Town or Lo		· · · · · · · · · · · · · · · · · · ·	·						10d. Inside City Limits 1 ☐ Yes 2 ■ No
is 23a or 2 nust be no	Funeral Di	10e. Street and Numb	per					ip Code 20	882			10g. C	itizen of \	What Cou	-
amin	2	11. Marital Status1 ☐ Never Marries3 ☐ Widowed 4		Armed Fo	2 🗭 No /e	.S. 13.	If Yes, spe		n, Mexica	an, Puerto i	cify Yes or No- Rican, etc.)		Blac	e - Ameri ck, White, Whi	
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Mental Hy larked oth atic event	10 Be	17. Father's Name (Fil George	rst, Middle, Last, Serabia	•					18. Moti		(First, Middle Laire A			*	
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ment of H ant: If ite ury or oth		20a. Method of Dispo 1 ■ Burial 2 □ 4 □ Donation 5	Cremation 3		State	Place of Disponentery, cre L Souls	matory or	other place	· .		Date 24,2010			-	fown, State Maryland
Depart Import any inj		21. Signature of Fune	anis Ol	Vauley (I Z	101es 26401	Klag	s of Facil -Wil e Ro	lity liams ad, I	s, P.A. Damascu	, Fu	mera	1 Hc	
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certific irector,	ן ב	25. Was case referred examiner? 1 ☐ Yes 2 ■		Hospital:		1		Other	r.	ath (Check			_		
after death. Director: After this c in by the funeral director.	. 1	27. Manner of Death 1 Natural 2 Accident	5 Pending	28a. Date (Moni	Inpatient 2 of injury th, Day, Year)	28b. Time o injury		28c. Injury work?	at	2	ne 5 Resi				y) Hospice
urs after de ral Directo lled in by th		3 ☐ Suicide 4 ☐ Homicide	6 U Could not determined	28e. Place	of Injury - At h ng, etc. (S <i>pecif</i>		eet, facto	y, office		2	28f. Location (City or Tov			er or Rura	d Route Number,
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DO COL	1	29b. Signature and titl Joce	e of certifier Lyn e	Koud	tchoi	l, mi) 29	c. License D 63	number 7 L	18			ite signed 11y 2		Day, Year) 2010
15	-	30. Name and address Jocelyne	Touken	Vouetch				ersit	y Pa	rkway	, Balt	imor	ce. M	1D 21	218
State Registrar	3	31. Date filed (Month,	Day, Year) 2	2 2010 B	egistrar's Signa				<i>y</i>		,		_ , _		

DHMH 17 Rev 7/2009

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State Registrar

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DHMH 17 Rev 1/2001

Zabiullah Ali, M.D.

31. Date filed (Month, Day Y. AIIG 0 2 2010

ORIGINAL

son who completed cause of death (Item 23a)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 23, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State Registrar Amend Items State of Maryland / Department of Death Mental Hygiene Certificate of Death Reg. N2 0 1 0 247 1
e	Physici /Medi		1. Decedent's Name (First, Middle, Last) RONNIE RUFORD Helmich I 2. Date of Death Month Day Year 1839 M
	Examir Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County o
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 138 ALLEGANY CUMBERLAND 1 Yes 2 No
	th with the 23a or 28 ast be no	al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 138 INDEPENDENCE ST 2150Z USA
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Extractivate must be rediffed at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes 2 No Specify: 17. Specify: CAUCA SIAN
21215-0036	led within 72 ho lygiene. her than "natur it, Ire Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER 16b. Kind of Business/Industry RESTAURANT
Maryland 2	2 should be filed and Mental Hygis is marked other aumatic event, III	To Be C	17. Father's Name (First, Middle, Last) RUNNIE R. HELMICK, SR 18. Mother's Name (First, Middle, Maiden Surname) Constance Cheshire
	s 1 and 2 sh of Health and item 27 is m other traum		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RDNNLE R. HELMICK, SR 500 CRDW DR. WINCHESTER, VA 2Z602 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore,	permit. Pages Department of Important: If it any injury or o once.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M01582 Cremation of the place of Funeral Service Licensee M01582 Cremation Service 07/27/2010 Winches Tensor of Facility Omps Funeral Service Licensee
	222 6 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):
8760,	ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):
O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year Year
ords, P.	equires that en signed b ould be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	hysician: The law rethis certificate has be	Completed	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
of Vii	y Physicia er this cert eral directo	To Be	25. Was case referred to medical examiner? Mospital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Mospital: 6 Other (Specify)
Division of	r Attending ter death. Irector: Afti I by the fun	Certification: To	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation 7 2 - 10 U F M 1 Yes 2 No PT HUNGING HUNGE F F F F F F F F F F F F F F F F F F
Ω	Hospital of 24 hours af Funeral Distely filled in	edical Cer	29a. Certifier (Check only one) 132 (NDEFERGINE) 132 (NDEFERGINE) 133 (NDEFERGINE) 133 (NDEFERGINE) 134 (NDEFERGINE) 135 (NDEFERGINE) 137 (NDEFERGINE) 138 (NDEFERGINE) 139 (NDEFERGINE) 140 (NDEFERGINE) 150 (NDEFERGINE
	To the within To the comple	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 22 201
			20 News and address of seven who consists of seven the consists of seven the
	Stat Registra		PALL SNOW, Map Dot y Med EX 124 a 3 h 3 + Cundenture Mo 31. Date filed (Month, Day, Year) AUG 06 2010 32. Registrar's Signature August A. January August A. Janu

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar				rtment of I tificate of			Reg. N	2010	247
Physicia	an	1. Decedent's Name (First, Middle,	Last)					2. Date of D		ay Yea	3. Time of
/Medic		Doris B. Hamm	ann					July	27		
xamin	er	4a. Facility Name (If not institution,	give street and number)			4b. City, Town, c	or Location of Death	1		c. County of De	
		Autumn Assist		n /lm ium l	and friedly of a col	Hagerst	OWN If Under 24 Hrs.	1 0 D-1(D		ashingt	
neral ector		214-12-7589	6. Sex 7. Ag 1. ☐ M 2. ☐ F	, ,	as <i>t birthday)</i> O / Yrs.	Months Days	Hours Min.	8. Date of B	Day, Year	7) (irthplace (State o
		Usual Residence of Decedent			94 115.			Sept.3	,191	o was	shington,
any Injury or other traumatic event, the Medical Examinat rount to notified at once.		10a. State 10b. County		10c. City	, Town or Loc	ation					10d. Inside Cit
Illea	ctor	MD Wash:	ington	На	ncock						1 X Yes
S, De	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What (Country?
	ral	34 Cleveland	Drive			21750			US	A	
	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		5. 13. V	as Decedent of F Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No Rican, etc.)	10-	14. Race - An Black, Wh	nerican Indian, ite, etc.
İ	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	d 1 □Yes 2 ☑ If Yes, Give Year or Dates;	No	1	□Yes 2 No	Specify:			Specify: 1	White
		15. Decedent's			16a, Deced	ent's Usual Occup	nation		16h	Kind of Busines	
	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)		(Give F life. D	aind of work done O NOT use retire	during most of word)	king	1001	Tana or Babilloo	ormacon y
	mo;	12	College (1-4or 5)+)	Home	maker			0	wn Home	!
	Be C	17. Father's Name (First, Middle, La	ast)				18. Mother's Nan	ne (First, Middl	e, Maide	n Surname)	
	2	Frederick Budd	ecke				Li1	lian P1	itt		
		19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailing	g Address (Street	and Number or Ru	ıral Route Num	ber, City	or Town, State	, Zip Code)
		Arnold E. Hamman	nm/Son				Avenue Ha				
- 1		20a. Method of Disposition 1 Burial 2 □ Cremation 3	B □ Removal from State	20b. Pi	ace of Dispos emetery, crem	ition (Name of atory or other plac	ce)	Date	20c. I	Location - City o	or Town, State
		4 ☐ Donation 5 ☐ Other (Spe	ecify)	Ced	ar Law	n Mem.Pa	rk 07/31	/2010	Hag	erstown	, MD
nce.		21 Junature of Funeral Service A			22.	Name and Addre	ess of Facility 14	1 West	Mai	n Stree	t
Э		Toch)/	100 MO0260				ral Home,			k,MD 21	
В		23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that caused nly one cause on each lir	the death ne.	. Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Bety Onset and D
n		Immediate Cause (Final disease or condition resulting in death)	_aA	cit	no	o Cendra	1 Inp	erch	_		to m
al er		rosalling in deathy	Due to (or as	a consequ	ence of):						
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequi	ence of):						ļ
	Ë	cause (Disease or injury that initiated events	1	a comoqu	01.00 01/1						
	Examiner	resulting in death) Last	C Due to (or as	a consequ	ence of):						
	dical		d.								
-	ledi										
ļ	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	***		1	23d. Date of d	elivery
	sici	in the past 12 moeths? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify) _	·',			Month	Day Y
	Phy	9 Unknown									
	þ	Part II. Other significant condition				derlying cause giv	en in Part I.				to the cause of de
	ted	- MASTERIA	- Coper 1		recia				Yes 2	2 NO 3	Probably 4
	Completed							24a. Wa auto	Opsy	prior to	autopsy findings a completion of ca
								pen 1 □ Yes	formed? 2 ☑ N	death1 o 1 □ Ye	s 2 🗆 No
	Be	25. Was case referred to medical examiner?	Hospital:			3 🗆 DOA Oth	26. Place of Dea				4070 P
	Certification: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatie		R/Outpatient 28b. Time of	3 LI DOA					pecify) Ass
	tio	1 ■ Natural 5 Pending	(Month, Day	v, Year)	Injury	28c. Injur Worl	yat k? Yes 2 □No	28d. Describe	now inju	ary occurred	
	fica	3 ☐ Suicide 6 ☐ Could no	the	ırv - At hor	ne, farm, stre		163 2 140	28f Location	(Street a	and Number or i	Rural Route Numi
	erti	4 ☐ Homicide determin	ed 28e. Place of Inju- building, etc	. (Specify))	, , ,		City or To	wn, Sta	te)	Tarai France Teams
		29a. Certifier 1 ☐ Certifying	Physician: To the best of	of my know	ledge, death	occurred at the ti	me, date and place	, and due to th	e cause(s) and manner	as stated.
1	Medical	(Check only 2 Medical Ex	caminer: On the basis of and manner sta	f examinati	on and/or inv	estigation, in my o	opinion, death occu	rred at the time	e, date ar	nd place, and di	ue to the cause(s)
	M	29b. Signature and title of certifier				29c. Licens	e number		29d. D	ate signed (Mo	nth, Day, Year)
		-	Tat MO			Do	DIBDIA	4	3	14 2°	7,2012
		30. Name and address of person wi	no completed cause of de	eath (Item	23a) (Typę, P	rint)				4	170011
		VASANT DA	TA M. S.3	40 M	1111 51	HAGER	STOWN	mb .	217	40	
		ALIDAKI DA					The same of the sa		- 6	, -	
		31. Date filed (Month, Day, Year)	32. Registra	ır's Sigratu	ıre	1 1					
Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ire	1. par	STOWN W				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ye ar $7^{\text{Month}}_{-3}1 - 20^{\text{Day}}_{10}$ GEORGE THOMAS HUTCHINSON 11:20PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8995 FAIRGROUNDS ROAD BEL ALTON CHARLES 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7-16-1929 9. Birthplace (State or Foreign Country)
N • Y • 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days Hours Min. 056-22-8142 81 Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MD. Director CHARLES BEL ALTON 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 8995 FAIRGROUNDS ROAD 20611 23a U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No NA If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after NAVY KOREA 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: WHITE 3 □ Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
ELECTRICAL ENGINEER etired) L ENGINEER ARCHITECTURAL than Elementary/Secondary (0-12) College (1-4or 5+) ENGINEERING FIRMS 12 alth and Mental Hygical S7 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be GEORGE HUTCHINSON MARY DYSKO traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a THOMAS J.HUTCHINSON-SON 8995 FAIRGROUNDS RD. BEL ALTON, MD. 20611 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial ② Cremation 3 ☐ Removal from Sta METROPOLITAN CREMATORY 8-2-10 4 ☐ Donation 5 ☐ Other (Specify) ALEX., VA. M00479 Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
T.A PI,ATA, MARYLAND 20646 21. Signature of Fune al Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner enile Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. the 1 ☐ Yes 2 ☐ No. 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy certificate 2 🗆 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ 🙀 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide i 24 hours after e Funeral Dire letely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Registrar 24) DHMH 17 Rev 1/2001

Dr

соmpletely

State

within 2

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Month P^{M} <u>Anne Friedman Isikoff</u> Julv05 5:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington <u>Rockvill</u>e Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Hours (Month, Day, Year) 02/19/1915 North Director 95 Yrs. 222-16-4570 Dakota Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If ifen 27 is marked other than "natural", or items 23a, any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be Funeral 6121 Montrose Rd 20852 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Publishing <u>Administrator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည "Unknown" Peter Friedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16th Street #24 Silver Spring MD 20910 <u>Peter Isikof / Son</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) David Mem. Grdns 07/08/2010 King Falls Church, VA 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc. 21. Signature of Funeral Service Lit MO1477 **Blake** 1170 Rockville Pike Rockville, MD 20852 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ neumoni disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been si funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural Acciden 5 Pending Accident Suicide within 24 hours after death

To the Funeral Director;

completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numbe 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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MONTROSE

M.D

Redistrar's Signat

20852

10-05357 Deborah R. Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate o	of Health and Iv of Death	, ,	2010 Reg. No.	24110
Physici lical Exami		Decedent's Name (First, Middle, Last) Deborah Ruth Wash	ington Jone	es	2. Date of Dea Month July 17, 2	Day Year	Time of Death 2338 hrs
		4a. Facility Name (if not institution, give street and number))	4b. City, Town, or Loca Temple Hills		4c. County of Death Prince George's	
Funeral Director			ge (In yrs. last birthday)	If Under 1 Year If	Under 24Hrs. 8. Date of Bi	irth(MM/DD/YYYY) 9. Birthp	lace (State or Washington
Difector		578-78-5498 1 M 2 X F Usual Residence of Decedent	52 Yr			27,1958 Count	D.C.
ow any		10a. State 10b. County	10c. City, Town or Loca				Od. Inside City Limits X Yes 2 No
farylanc 28a-f sh at onc	Director	Maryland Prince Georges 10e. Street and Number	Suitla	10f. Zip Code	1	10g. Citizen of What Country	
th the N 23a or 7 notified		5703 Auth Road		20746		United State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once,	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces 1 Yes 2			Origin? (Specify Yes or No kican, Puerto Rican, etc.)	14. Race - Americar White, etc.	n Indian, Black,
rs after ural", o	by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade con	1	Yes 2 X No spention (0		Specify: Blace 16b. Kind of Business/Indu	
o 72 hou an "nati cal Exa	ompleted	Elementary/Secondary (0-12) College (1-4 or	5+) during n	nost of working life. DO I	NOT use retired)		·
5-0036 iled within 7 Hygiene. I other than the Medica	Comp	12th grade 17. Father's Name (First, Middle, Last)	St	ore Manage	cother's Name (First, Middle,	Safeway Food Maiden Surname)	ds Stores
Mental Hi Mental Hi marked o	Be	Clarence William Monro		1	Margo Juanit	a Washington	
d 2 shoul fith and M n 27 is m	To	19a. Informant's Name/Relationship (Type, Print) Sean Rai Beasley (Son)	1			mber, City or Town, State, Zi Virginia 232.	
of Healt of Healt If item		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta	20b. Place of Dispos	sition (Name of cemeter	July 24,20	20c. Location - City or Tox	
permit. Pages l ar permit. Pages l ar Department of He Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Chesapeak	ce Crematory	y, Inc.	Beltsville,	
		Sandach B. Aute	In	c.;600 Keni	nedy Street,N	.W.;Washingto	on,D.C.200
hysician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line. Immediate Cause (Final disease a, Atherosclerotic	the death. Do not enter t Cardiovascular Dis		as cardiac or respiratory arr		Approximate Interval Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a conse					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):				
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	equence of);				
ate be executed obysician and ne burial - transit		d. UNPENDED AMENDED					
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	cian/Medical	IF FEMALE: 23c. If yes, outcon 1 Live birth			topic pregnancy	23d. Date of delivery Month Day	Year
e death certifical the attending ph ed for use as the	sicial	past 12 months?	time of death	etal death 3Ec ther (Specify)	topic pregnancy	INIONIN Day	164
es that the de gned by the	P Py	Part II. Other significant conditions contributing to death	n but not resulting in the u	underlying cause given i	n Part I. 23e. Did to	obacco use contribute to the	cause of death?
quires that en signed l uld be deta	eted by				1 ✓ Yes 24a. Was	s 2 No 3 Probabl	y 4 Unknown
e law requir e has been s ge 2 should	Comple				autop perfoi	osy prior to comp rmed? death?	pletion of cause of
	Be Co	25. Was case referred to medical examiner?			eath (Check only one)	2 No 1 Yes	2 No
the Hospital or Attending Physician: The law requiring the Yahours after death. the Funeral Director: After this certificate has been simpletely filled in by the funeral director, page 2 should the	2	1 ✓ Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 28a. Date of Inju				Residence 6 Other: So	ene
tending leath tor: Af the fun	ation	1 V Natural 5 Pending (Month, Day, You 2 Accident Investigation	ear)		No	,,	
pital or Attendions after death. leral Director: / filled in by the fi	Certification	3 Suicide 6 Could not be determined (Specific)	ury - At home, farm, stree	et, factory, office building	g, etc. 28f. Location (S or Town, S	Street and Number or Rural F state)	Route Number, City
hour ner: v fill		29a. Certifier (Check only 1 Certifying Physician: To the best of my					
Fu etely		one) 2 Medical Examiner: On the basis of exam	nination and/or investigat	tion, in my opinion, deatl	h occurred at the time, date	and place, and due to the ca	iuse(s)
To the How within 24 h To the Fur completely	Medic	and manner stated. 29b. Signature and title of certifier		29c License num	ber	29d Date signed (Month	
To the Ho within 24 To the Fu completely	Medical	and manner stated.	11	29c. License num O.C.M.E.	ber	29d. Date signed (Month, July 23, 2010	
To the He within 24 To the Fu completely		and manner stated.	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per med cert G907 9/15/10 dk.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4:30A M July 20, 2010 David Charles Keener /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9943 Canvasback Way Damascus Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

California 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1**℃** M 2□ F Yrs. 222-60-2844 45 Director May 19, 1965 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9943 Canvasback Way Completed by Funeral 20872 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Food Industry permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Loriel Ann McGrann John Charles Keener ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Adriana Keener - Wife 9943 Canvasback Way, Damascus, Maryland 20872 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium 7/21/10 Alexandria, Virginia 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Fuperal Service Licenses 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastahe panereahe cancer **Physician** 1200 /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 XNo Medical Certification: To 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined ₹☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D53070 July 21,2010 em, mD

State Registrar DHMH 17 Rev 1/2001

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Hospital 1650 Orleans St Balt, MD 21231

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day Yaar) 22

Dhy Hoking
32. Registrar's Signature

		_ For	epartment of Health and Me	ental Hygiene											
		negistiai	Certificate of Death	Reg. 2010 2411 2. Date of Death 3. Time of Death											
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Phyllis M KNepp		July 28 2010 11:35 PM											
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death											
Funeral		3166 Garrett Highway 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Oakland fay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)											
Director		218-30-0218 1 N 2 XF 78 Yr	s. Months Days Hours Min.	08/22/1931 MD											
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location	10d. Inside City Limits											
Maryi I-f sho	tor	MD Garrett Oakla	nd	1 □Yes 2 🛣 No											
th the or 286	Direc	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?											
s 23a	Funeral Director	3166 Garrett Highway	21550	United States city Yes or No- 14. Race - American Indian,											
ter de	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	 Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F 	rican, etc.) 14. Hace - American Indian, Black, White, etc.											
ours a	2	3 🕅 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🌠 No Specify:	Specify: White											
filed within 72 hours after death with the Maryland Hygiene. Hygiene, with "natural", or items 23a or 28a-f show ent, the modical Even included an notified at	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed)	16b. Kind of Business/Industry												
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permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Eventual or other traumatic event, the Modical Eventual or other traumatic event.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility David A. Burdock												
89 = 89		* Katherine Swritzer	21 N. Second St.,	Oakland, MD 21550											
Physician /Medical Examiner	ler	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Interval Between Onset													
ificate be executed g physician and is the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	:												
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⊒ E E	Certification:	Alatural 5 Pending (Month, Day, Year) Injunction S Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 □Yes 2 □No	28f. Location (Street and Number or Rural Route Number, City or Town, State)											
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To the within To the comp	Me	29b. Signature and title of certifier Margaret a Kain W	29c. License number D 266 50	29d. Date signed (Month, Day, Year) 7-29-2010 ay pakland, M. 2155											
•	12	30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	as allowed hed some											
Sta Registr		31. Date filed (Month, Day, Year) JUL 3 0 2010 32. Registrar's Signature	Land Market Market	y concerd in asissi											
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Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	Registrar			Certific	ate of E	eath			Reg. N	20	IU	2	4/	10
	1. Decedent's Name (First, Middle	, Last)						2. Date of De	eath			3.	Time of I	Death
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cal ier	4a. Facility Name (if not institution,			4b. 0	City, Town, or	Location of	of Death			c. County				
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	F. Elaine Kimm	nell, Wife		16 Harv	zey Rd	., 0a	klan	d, MD	<u> 2155</u>	0				
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	21. Signature of Funeral Service L		T G G M.D G	e and Addres	s of Facilit	v					•			
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	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,													
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ica S	29a. Certifier 1 X Certifying	Physician: To he best of	my knowledge,	, death occure	d at the time,	date and p	olace, and	d due to the ca	ause(s) a	and manne	er as stat	ted.		
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17	30. Name and address of person v Robert A. Gora			(Type, Print) Fourth	St	Oak1	and	MD 21	550					
Ĺ	31. Date filed (Month, Day Year)						وسيين	21.						
e		3 A A A A I 32. Reculstra	ar's Signature 🌶	Land										

State Registrar 10-05782 Harold Knode Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend State of Maryland / Department of Health and Marklan Hygiene

larold Knode		State of Maryland / Department of Health and Mental H 1-For State Amend Items 28b, e per me 1890 of Beath Registrar Certificate of Death	lygiene	Reg. No.	201	0 24719							
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Harold Edward Knode, Jr.	2. Date of De Month August 1	eath Day	Year	3. Time of Death 2140 hrs							
		4a. Facility Name (if not institution, give street and number) University of Maryland Hospital 4b. City, Town, or Location of Death Baltimore			County of De								
Funeral Director		5. Social Security Number 220-28-3649 6. Sex 1. Months 2 F 76 76 76 77. Age (In yrs. last birthday) 6. Sex 1. Months 2 F 76 76 77. Age (In yrs. last birthday) 77. Age (In yrs. last birthday) 77. Age (In yrs. last birthday) 78. Months 2 F 1. Months 2 F 1. Months 2. M				Birthplace (State or eign Country)Maryland							
Varyland 28a-f show any 1 at once.	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Frederick Frederick				10d. Inside City Limits 1 Yes 2 No							
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 5333 Reels Mill Road 21704		ountry?									
uter death wi	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced of If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		White, etc.	erican Indian, Black, nite							
5-0036 led within 72 hours a Hygiene. other than "naturs the Medical Exami	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Operating Engineer				ŕ							
ID 21215-0036 should be filed within 77 and Mental Hygiene. 77 is marked other than natic event, the Medical	Be	Harold Edward Knode, Sr. Evelyn	Lakel	e, Maiden Surname)									
ore, MD 2121 s. 1 and 2 should be fi of Health and Mental If item 27 is marked her traumatic event,	To	19a. Informant's Name/Relationship (Type, Print) Mrs. Penny D. Dickensheets, Dau: 19b. Mailing Address (Street and Number of 10298 Athabasca Trail	1, New			21774							
Page Frot		14 Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery Aug.	Ť	-									
Balti permit. Departin Imports injury o		21. Signature of Funeral Service Licensee M00255 22. Name and Address of Familias For Nee Files Address of Familias Fo	t., Fre	deric	k, MD	21701 Approximate Interval							
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Self-Inflicted Intraoral Gunshot Wound Due to (or as a consequence of):				Between Onset and Death							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause											
executed an and al - transit	l Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.											
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Box 6876(e death certificate the attending phyself for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	ancy		onth	Day Year							
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Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Certification:	3 2 Society 6 Could get be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (or Town, 5 5333 Reels N			ural Route Number, City							
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To with To con	Me	29b. Signature and tife of certifier O.C.M.E.			te signed <i>(M</i>	onth, Day, Year)							
		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201										
St Regist	GCC	31. Date filed (Month; Day, Year) 32. Registrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year Kathleen July 21, Breen Linaugh 12:26 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Dec. 14 Year) 1939 **Director** 578-54-2120 70 D.C. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2🙀 No Maryland Montgomery Rockville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 11848 Farmland Drive 20852 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 it. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Menta once. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Joseph Breen Catherine Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip James Linaugh/Husband 11848 Farmland Drive, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery Jujy 27 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pulmonary Hypertension Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Year Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease with Acute Kidney Injury 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 724 hours after death.
Funeral Director, After this certific upleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 T No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Fractioner To the basis of any highest of any opinion and at the time, date and due to the retiredly and manner set talks. within 2 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) July 21, 2010 2 D67986 MiD

Registrar
DHMH 17 Rev 7/2009

State

LINAUGH,

8600 Old Georgetown Road, Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Yuneng Li, MD

23

31. Date filed (Month, Day, Year)

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 State	epartment of Health and N Certificate of Death	711111 74171
		Registrar 1. Decedent's Name (First, Middle, Last)	Dertificate of Death	2. Date of Death 3. Time of Death
Physi /Med		NaeQuan Laws		16:02M
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funera		The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. lest birth		8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Directo		219-87-8123 XM 2 F	months Days Hours Min.	June 15,2010 Maryland
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town		10d. Inside City Limits
Maryl a-f sho ied at	ţo		ke City	XXYes 2 □ No
th the or 28a	Director	10e. Street and Number	10f. Zip-Code	10g. Citizen of What Country?
s 23a	eral	612 Cedar Street	21851	USA
15-UU36 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	Funeral		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
5-UU36 72 hours aft natural", or ical Examir	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: Black
	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. I	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	aing 16b. Kind of Business/Industry
nd Z1Z1 e filed within al Hygiene. other than "	l mo	Elementary/Secondary (0-12) College (1-4 or 5+) 0 in	nfant	infant
nd in its all Hyg	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden Surname)
aryland should be fil nd Mental H marked oth	ြ	Nathan Marcus Laws, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. I		a Bonneville ral Route Number, City or Town, State, Zip Code)
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2				Pocomoke City, MD 21851
re, IV		20a. Method of Disposition 20b. Place of I	Disposition (Name of crematory or other place)	Date 20c. Location - City or Town, State
Saltimo		4 Donation 5 Other (Specify)	nai Cem. 7/23	3/2010 Pocomoke, MD
DallIMOTE, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral/Service Licensee	22. Name and Address of Facility Holloway Funeral	Home, P.A.
		23a. Part 1. Enter the disease, or complications that caused the death. Do no	107 Vine Street, t enter the mode of dying, such as cardiac	Pocomoke, MD 21851 or respiratory arrest, Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	N	Interval Between Onset and Death
/Medical Examiner		resulting in death) a. Due to (or as a consequence of		
LAGIIIIIei	e e	if any, leading to immediate b. Due to (or as a consequence of	Heart Disease	
nted I ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	
e exectan and and and and and and and and and a		resulting in death) Last Due to (or as a consequence of	× ·	
ifficate be executed g physician and as the burial-transit	edical	d		
certific	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
death e atten	Physician/M	in the past 12 months? 1	3 Ectopic pregnancy 5 Other (specify)	Month Day Year
at the by the etache	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying equal cities is Red I	23e. Did tobacco use contribute to the cause of death?
ires th	d by	, are in. Other significant conditions continuously to death but not resulting in	the underlying cause given in Fart i.	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
w require	olete			24a. Was an 24b. Were autopsy findings available
The lay	Completed		-	autopsy prior to completion of cause of death? 1 ★ Yes 2 □ No 1 □ Yes 2 □ No
cian:	Be (25. Was case referred to medical examiner?		(Check only one)
Physic this or ral dire	요	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outp 27. Manner of Death 28a. Date of Injury 28b. Tir		me 5 Gesidence 6 Gesidence Other (Specify) 28d. Describe how injury occurred
rding tth. : After e fune	ation		work? M 1 ☐ Yes 2 ☐ No	200. Document III III y coodined
r Atter rer dea rector	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
pital o	O	29a. Certifier 12 Certifying Physician: To the best of my knowledge, of	death accurred at the time, date and place	and due to the cause(s) and manner as stated
To the Hospital or Attending Physician: The law requires that the death certification is the hours after death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	edical	(check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occur	and due to the cause(s) and mariner as stated. red at the time, date and place, and due to the cause(s)
To the comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		- Jacul Would line	RES-000	JULY 20, 2010
BAI		30. Name and address of person who completed cause of death (Item 23a) (T		North Wolfe St, Baltimore, MD, 21287
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		Total Trong of, Bullinois, Ind., 21201
Regist	rar	JUL 2 3 2010 Jenera A.	backer	

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

		For State Registrar		State of	iviaryian		artment of F rtificate of I		ia ivier		eg. No		24722	
			ne (First, Middle, La	st)						Date of Deat Month	h Da	y Year	3. Time of Death	
Physicia /Medic		Versie	Luster							July	20		11:32 A. M	
Examin		4a. Facility Name (If not institution, give Valley 1	e street and nun	nber)		4b. City, Town, or		Death		4c	. County of Dea	th	
		Wellnes 5. Social Security N	s Center		7. Age (In yrs. I	ant hirthday	Roc	kville	Hrs. I a	Date of Birth		Montgome	tholage (State or Foreign	
Funeral Director		577-28-C	1 4	M 25€F	7. Age (III yis. I	Yrs.	Months Days		Min.	(Month, Day,	Year)		thplace (State or Foreign ountry)	
		Usual Residence o	of Decedent					ļ <u> </u>	102		714			
eath with the Marylanns 23a or 28a-f show	<u>_</u>	10a. State	10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
he M.	Director	Md. 10e, Street and Nu	Prince (eorge's		Capito	ol Height	S		1	Oa Ci	tizen of What Co	•	
with with the salor	Ö			3				42		1			Januty.	
er death w items 23a	Funeral	11. Marital Status	Sheriff Ro	12. Was Dece	dent Ever in U.S	S. 13.	207 Was Decedent of H If Yes, specify Cuba		? (Specify	Yes or No-		S.A. 14. Race - Ame		
aft aft	þ		ried 2 ☐ Married 4 ☐ Divorced	Armed For 1 ∐Yes If Yes, Giv Year or Da	2 X No		1 □Yes, specify Cuba	Specify:	ruerto Hica	an, etc.)		Black, Whit	e, etc. Black	
72 hc	Completed	(Spec	15. Decedent's Ed	ducation ade completed)		(Give	dent's Usual Occup	during most of	f working	- 1	16b. K	(ind of Business	/Industry	
within ene. than '	dmo	Elementary/Seco	ondary (0-12)	College (1-	4or 5+)		DO NOT use retired Oster Par	•			ח	.C. Gove	ernment	
filed Hygi other ent, II	Be Co	12th 17. Father's Name	(First, Middle, Last,)			DECE TUE		Name (Fi	irst, Middle, I			. I I II I I I I I I I I I I I I I I I	
ild be fental rked c	To B	Russell	Johnson					Jenr	nie G	reen				
shou and N s ma		19a. Informant's N	lame/Relationship (Type. Print)		19b. Maili	ng Address (Street	and Number	or Rural R	oute Number	r, City	or Town, State,	Zip Code)	
and 3			ster/Daug	ghter			Sheriff						20743	
permit. Pages 1 and 2 should be flied within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, It. Medical Evanone.		20a. Method of Dis 1	sposition Cremation 3 5 Other (Specil	Removal from S	state i		osition (Name of matory or other place Mem. Par		Date 7/26/			ocation - City or ndover , N	Maryland	
permit. Depart Import any inj		21. Signature of Fi	uneral Service Licer	nsee nsee	Rat	Z 49	2. Name and Addre Henry S 925 Burro	ss of Facility • Washi ughs Av	ingto	n & So	ons ash	Co.,Ind	C. 20019	
Physician		23a. Part 1. Eru r t shock, or hea Immediate Cause disease or condition resulting in death)	on	plications that ca one cause on ea	aused the death	n. Do not en	ter the mode of dyir	ng, such as ca	ardiac or re	espiratory arr	est,	Ingcom,	Approximate Interval Between Onset and Death	
/Medical Examiner	<u>.</u>			b	or as a consequor as a consequ									
cuted nd ransit	Examiner	Sequentially list co if any, leading to in Cause (Disease or that initiated events	S	C	or as a consequ	derice oi).								
tificate be executed g physician and as the burial-transit	edical Ex	resulting in death)	Last	Due to (or as a consequ	ience ot):								
ng phy as th		IE EEMALE.									- 1			
To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Physician/N	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1 Live b	come of pregna pirth 2 ☐ Fetal nant at time of d own	Ideath 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	у				23d. Date of de Month	blivery Day Year	
s that med b	by Pr	Part II. Other signi	ificant conditions	contributing to de	ath but not resu	ulting in the υ	ınderlying cause giv	en in Part I.		23e. Did to	bacco	use contribute t	o the cause of death?	
equire en sig ould b	ed b		Devo-Cu	-					- 1	1 □ Y	es 2	2 No 3 □ F	robably 4 🗆 Unknown	
The law reate has be page 2 sho	Completed								_	24a. Was a autops perform 1 □ Yes	sy	prior to death?	utopsy findings available completion of cause of s 2 \(\subsection \) No	
Iclan: certific ector,	Be (25. Was case reference examiner?	/	Hoonital			Oth	/		check only on				
Physic ral dir	٢.	1 ☐ Yes 2 2 27. Manner of Dear		Hospital: 1 □ I 28a. Date	npatient 2	ER/Outpatie		4 Nursi		5 Reside		6 ☐ Other (Sp.	ecify)	
th. : After	tion	1 Natural 2 Accident	5 Pending investigatio	(Mont	h, Day, Year)	Injury	Wor	k? Yes 2∐No		. Describe in	ow myc	ary coodined		
after deal Director	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28e. Place	of Injury - At ho ng, etc. <i>(Spe</i> cif	ome, farm, st	reet, factory, office		28f.	Location (S. City or Town	treet a n, Stat	and Number or F te)	Bural Route Number,	
e Hospita 24 hours e Funera eletely fille	edical C	29a. Certifier (Check only one)			asis of examina		th occurred at the ti							
To th Within To th comp	Me	29b. Signature and	d title of certifier	00.	1		29c. Licens	0 0 /	0	2	29d. D.	ate signed (Mor	th, Day, Year)	
1		Ita	neuc	Alle	elle	MI		3826)	-		uly 21	2010	
A.		PYAN	Iress of person who	PATERA	e of death (Item	1 Res	Print)	PLVD	Roc	tevel	le	MOZ	20850	
Sta Registra		31. Date filed (Mor	nth, Day, Year)	Several 32. R	egistrar's Signa	and	,							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 2010 Year **Physician** AUGUST FRANCES 2 **JEAN** LAMBERT 12:05a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Chestertown 23560 Canvasback Rd. Kent 8. Date of Birth (Month, Day, Nov 22 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Year) 1924 Months Days 1 ☐ M 2 🔀 F Maryland Nov 218-20-8535 85 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2√ No Director MD Kent Chestertown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code should be filed within 72 hours after death with and Mental Hygiene. 23560 Canvasback Rd. 21620 U.S.A. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 3€ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I **other than** " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental William Patrick Sadie Knotts ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an Health em 27 J William Lambert (husband) 23560 Canvasback Rd. Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important; If It any Injury or o 1 Surial 2 ☐ Cremation 3 ☐Removal from State Chester Cemetery 8/5/10 Chestertown, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a Insequence of): disease or condition resulting in death) /Medical Examiner dayons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for select Examiner The law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1∐ Yes 2 🔀 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 🗶 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific H0056426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 S. Katz, DO Bohemia Ave. Cecilton, MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24724 1 - For State Registrar Certificate of Death Rea. No. 1. Deced Middle, Last) 2. Date of Death ESME 3. Time of Death Physician/ Month 2010 2:20 a July 20 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bedford Court Assisted Living Silver Spring 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) NY 1 M 2 XF Days Hours Min. 1/22/1911 Director 579-42-1724 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3700 International Drive #237 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify Specify 3X Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jacob Epstein Mary Shintzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lynn Goldstein, daughter 20902 612 Sisson Street, Silver Spring, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State King David Meml Gdns 7/23/2010 Falls Church, Virginia 4 Donation 5 Other (Specify) DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC Signature of Funeral Service Licenses MO1477 23a Part 1. Enter the dis Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Gastric Cancer <u>Months</u> disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events kamine Due to (or as a consequence of): attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 signed by t d be detach has

the Hospital or Attending Physician: The law requires that the death certificate be executed certificate After this

FOICSI E	resulting in death) Last	Due to (or as a conseq	uence of):										
ysiciali/int	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?												
_	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cau												
na)	Diabetes Mellitus	1 ☐ Yes	1 Yes 2 X No 3 Probably 4 Unknown										
combie					24a. Was an autopsy performed?								
0	25. Was case referred to medical examiner?	26. Place of Death (Check only one)											
2	1 ☐ Yes 2 ☐XNo	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗆	Home 5 Residence	Assisted 6X Other (Specify) Living								
Cate	27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred							
1 001	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
200		sician: To the best of my know iner: On the basis of examination				and manner as stated. ce, and due to the cause(s) and manner stated.							

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D38457

3801 International Drive, #211, Silver Spring, MD

29d. Date signed (Month, Day, Year)

July 21, 2010

20906

State Registrar

only one 29b. Signature and titl

31. Date filed (Month, Day, Year)

30. Name and address of person who coorpleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

Nakul Goyal, M.D. P.A.,

2010

within 24 hours after To the Funeral Direct

2

Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it at Indical Examination must be notified.

Baltimore, Maryland 21215-0036

	1 - For State Registrar	State of Ma		ertificate of		Mental Hygier Reg.۱	ZUUU	24725		
	1. Decedent's Name (First, Middle, Last)					2. Date of Death	10.	3. Time of Death		
an cal		Mays, Jr					2010 Year	3. Time of Death		
er	4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, o	r Location of Death	4	c. County of Deat	h		
	St. Thomas More Med	icial Co	mplex		Hyattsvi	.11e		George's		
	5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign buntry)		
	579-58-9192	/ 2 F	OI Yrs.				949	DC		
	Usual Residence of Decedent		40 00 7					4011110111		
_	10a. State 10b. County		10c. City, Town or L	ocation.				10d. Inside City Limits		
cto	DC				Washing	gton		1 X Yes 2 ☐ No		
ie	10e. Street and Number			10f. Zip Code	10g.	Citizen of What Co	untry?			
<u></u>	619 K Street NE				20002		United	States		
Jer.		. Was Decedent E	ver in U.S. 13.	. Was Decedent of I	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame			
ᆵ	1 □ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 🔀 N		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.		
φ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 No	Specify:		Specify:	rican		
b	15. Decedent's Educat		16a Dece	edent's Usual Occup	agtion	I 16h	Kind of Business	nerican		
et	(Specify only highest grade c	ompleted)	(Give	e kind of work done DO NOT use retire	during most of work	ring 100.	Titlid of Daoiness	madatry		
mc	Elementary/Secondary (0-12)	College (1-4or 5-	+) /// // // // // // // // // // // // /		epreneur		Self-Emp	oloyed		
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)				e (First, Middle, Maid	iden Surname)				
To B	Clarenc	e Mays S	Sr.		Ве	rtha Seay				
_	19a. Informant's Name/Relationship (Type	. Print)	19b. Mail	ling Address (Street	and Number or Rui	ral Route Number, Cit	y or Town, State, 2	Zip Code)		
	Deborah Mays/ Wife		619	K Street	NE Wash	ington, Do	20002			
	20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla			Location - City or	Town, State		
	1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Harmon	ny Memori	- 1		, Maryland			
	21. Signature of Funeral Service Licensele	4-17	2	22. Name and Addre		meral Home, Inc.				
	Athr 1. Stew	it II		4001 Benn	ing Road	NE Washir	gton, DC	20019		
	23a. Pirt1 Enter the disease, or complication, or heart failure. List only one	tions that caused cause on each line	the death. Do not er e.	nter the mode of dyi	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between		
	Immediate Cause (Final disease or condition	ARTHE	INCHEACT	or con	GA DIS	Onset and Death				
	resulting in death)		consequence of):	JC CASIPE	310474300	LAN DIS	EUN	Genry		
ē	Sequentially list conditions,	Due to Or as a	CuriSequence of):							
m;	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
Xa	that initiated events c resulting in death) Last	Due to (or as a	consequence of):							
edical Examiner										
gi	d									
/Me	IF FEMALE:	If was sutarma								
ian	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of 1 ☐ Live birth	2 Fetal death 3	☐ Ectopic pregnand	су	1	23d. Date of de Month	livery Day Year		
sic	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify) _			Workin	Day 1cai		
Phy	9 Unknown					00- 2111				
β	Part II. Other significant conditions contril	•	<u> </u>		en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?		
ed	Cenebral Thhon	100515	Biliete	ral Abi	Meknoe	1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown		
Completed by Physician/M	Respiratory Fa	ilune U	leutilato	ir Depen	rdence	24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of		
E O	Peripheral Arver					performed?	death?	completion of cause of		
Be C	25. Was case referred to medical	141 13	- CAR		26 Place of Boot	1 ☐ Yes 2 🔼	NO 1 LIYES	Z LINU		
~	examiner?				Zo. I lace of Deal	in (Oncor only one)				

Physician /Medical Examiner

and

has

To the Hospital or Attending Physician: The law requires that the death certificate be executed completely filled in by the funeral director, page 2 should be detached within 24 hours after death. To the Funeral Director: After

Division of Vital Records, P.O. Box 68760,

Respiratory	Failure U.	entilator	Dep	endence
Peripheral Ar	Verial Dis	20nde		
25. Was case referred to medical examiner?				26. Place of D
1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 □ DOA	Other: Nursing
27 Manner of Death	29a Data of Injury	29h Time of		lairene at

4 Homicide

29a. Certifier (Check only one)

ase referred to medical 2 No er of Death 1. Natural 2 Accident 3 Suicide

JUL 2 3 2010

5 Pending investigation 6 Could not be determined

Injury

28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

b. Signature and title of certifier	
	(10.)
Tour In	aum

29c. License number 201852

29d. Date signed (Month, Day, Year) JULY 16 2010

				_											
O Niema	0 000		-6 -		sade a	A	-1-			- 2	al a mala	/14	00-1	/Ti	D
io. Nain	e and .	address	Obl	erson	WITO	E UI	LIDIE	etea	cause	OI I	aeam	Hitem	2331	TIVDE.	Prin
			/ \							-:		4		1.31-01	
4 3		A	/				-		449	- A		6	-		á .

reensbury Rd Hyattsvilla MD 20781 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical Certification: To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			= State Amend Item 23	State of Marylan aPtI,II,25 p	d/Depa er me	rtment o 2906,08 tificate	f Health and N 106/2010dh Sr Death	⁄lental Hygi b Re	epe g. Ko. 010 2	4726				
В	Physici	an	1. Decedent's Name (First, Middle, Last)	arie Ma				2. Date of Death Month		3. Time of Death				
100	/Medic Examin		4a. Facility Name (If not institution, give st				n, or Location of Death		4c. County of Death	Lon				
		***	N/NS of Haust 5. Social Security Number 1 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 V		8. Date of Birth	9. Birthphe	e (State or Foreign				
	Funeral Director		215-44-7789	M 2□X 64	Yrs.	Months Da	ys Hours Min.	8. Date of Birth Month Day Aug 2	7, 1945 Countin	/ID				
	aryland show	_	Usual Residence of Decedent 10a. State MD 10b. County Washir	igton 10c. Cit	y, Town or Loc	erstowr	1		10d.	Inside City Limits				
	th the Ma or 28a-f	Directo	10e. Street and Number			10f. Zip Coo		10	Og. Citizen of What Country USA					
	eath wi	erai	14014 Marsh Pike	2. Was Decedent Ever in U	S. 13. V	Vas Decedent	of Hispanic Origin? (St	pecify Yes or No-	14. Race - American					
980	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show I.a Medical Evanther must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Xes 2 □ No	If	Yes, specify	Cuban, Mexican, Puerti X	o Rican, etc.)	Black, White, etc					
15-0	n 72 ho "natur	leted	15. Decedent's Educ (Specify only highest grade		16a. Deced (Give	lent's Usual Or kind of work do DO NOT use re	ccupation one during most of wor atired)		16b. Kind of Business/Indus	try				
21215-0036	giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker			Own Home					
	ild be fited fental Hygi rked other lic event, I	To Be (17. Father's Name (First, Middle, Last) Joseph A. Foote	n				sa I. Mee:						
Maryland	nd 2 should lith and Men 27 is marke r traumatic	. 8	19a. Informant's Name/Relationship (Typ Kathryn Ekstrom	^{e, Print)} sister	19b. Mailin 314	Piedmo	reet and Number or Ru nt Avenue	ral Route Number, Cumi	City of Town, State, Zip Coperland ML	21502				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantian must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	20b. Formoval from State	Place of Disposementery Crem DCKy Gar	sition (Name of natory or other O Veterar	ns Cemetery	7/30/2010	20c. Location - City or Town Flintstone	n, State MD				
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee 22. Name Scarpelli Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502											
		2 01	23a. Part 1 Enferthedisease, or complic shock, or heart failure. List only on Immediate Cause (Final	ations that caused the deat e cause on each line.	h. Do not ente Quadri j	er the mode of plegia	dying, such as cardiad	or respiratory arre	est, A In	pproximate Iterval Between Inset and Death				
7	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):		Cherr							
	Examiner	e	er	er	er	ler	Sequentially list conditions, b.	Due to (or as a conseq		tem Ini	arction	11	//	
	acuted ind transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				- A	M STEDICAL	EXAMINER					
8760,	ate be executed thysician and the burial-transit	dicai Ex	d	Due to (or as a conseq	uence or);		CERTIFICATION AP	PROVEDBY						
9	ertificati ling phy e as the	Medi	IF FEMALE:	c. If ves. outcome of pregna			CENT		and Date of delivery					
.O. Box	that the death certificate be execut ed by the attending physician and detached for use as the burial-frar	ysician/l	ysician/	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	1 Live birth 2 Feta 4 Pregnant at time of d	I déath 3	Ectopic pregn Other (specif			23d. Date of delivery Month Di	ay Year		
Ω.	w requires that the been signed by the should be detache	ed by Ph	Part II. Other significant conditions cont DI abelies	ributing to death but not res	ulting in the ur	nderlying caus	e given in Part I.		pacco use contribute to the es 2 □ No 3 □ Probab					
of Vital Records,	a 5 C	nplet	Tracheostum					24a. Was a autops perform	y prior to comp	y findings available pletion of cause of				
al B	Th ate pag	Con	25. Was case referred to redical				36 Place of Dec		1 Yes 2	□ No				
f Vit	Physicien: r this certific ral director,	To Be	examiner?		ER/Outpatien	t 3□ DOA	Othor		ence 6 Other (Specify)					
o uo	ding PI h. After th funeral	tion:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. Describe ho	ow injury occurred					
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specific	ome, farm, str	eet, factory, of	fice	28f. Location (St City or Town	reet and Number or Rural F n, State)	Route Number,				
	e Hospita 124 hours e Funerel letely filler	edical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death	n occurred at to vestigation, in	he time, date and place my opinion, death occu	e, and due to the caurred at the time, d	ause(s) and manner as stat ate and place, and due to the	ed. ne cause(s)				
	within To th comp	Me	29b. Signature and title of certifier	c n .	0	29c. Li	cense number	2	9d. Date signed (Month, Da	iy, Year)				
		in the second	30. Name and address of person who col	npleted cause of death (Iter	1 23a) (Type	Print)	118578		1-26-2011	/				
	7		14014 Marsh Pi	Ke Hapers	town	mp 2	1742 N	lichelle	2 Eyler C	PNP				
	Sta	de	31. Date filed (Month, Day, Year)	32. Registratus Signa	ature	arkel			V					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 07 Angela Margaret McAteer 2010 13:25 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frostburg
If Under 1 Year | If Under 24 Hrs. | Frostburg Village Nursing & Rehab Allegany Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 KF Hours Director 220-07-6839 94 27 1915 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Hem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinor must be notified at 1 Yes 2 No Director MD Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Taylor Street Funeral 21532 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainer. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Completed by Specify. 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter S. McGuire Margaret Egan McGuire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert McAteer son 18 Taylor Street Frostburg, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St._Michael's Cem 07-30-2010 Frostburg MD 22. Name and Address of Facility Sowers Funeral Home, P.A. 21. Signature of Funeral Service Licenses ower3 60 W. Main Street Frostburg, MD 21532 MO0547 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to () as a consequence of): /Medical Examiner Sequentially list conditions, if any lead of the model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Inknown should I 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an certificate has page 2 Hospital or Attending Physician: Tr 24 hours after death. Funeral Director: After this certificate tely filled in by the funeral director, pag 1 ☐Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred . J ☐ Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21244

State Registrar 31. Date filed (Month.

DHMH 17 Rev 1/2001

Dic

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Broad was

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie (2) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 2010 Mary H. Miller 31, July 11:40PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7921 Rolling View Avenue Nottingham Baltimore NOTTINGIAM

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Oct. 27, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Vre 218-32-9604 73 Director MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location "netural", or iteme 23a or 28a-f show ofical Examinar must be notified at 1 ☐ Yes 🏋 No MD Baltimore Nottingham Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 U.S.A. 7921 Rolling View Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Not: If item 27 is marked other than "netural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 →Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Almony Clara M. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana L. dela Cruz/Daughter 7921 Rolling View Ave. Nottingham MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. Date 5, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any njury or once. Stablers Cemetery 2010 Parkton, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 N. Second Street, New Freedom, PA 1734 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE HYPOXEMIC **Physician** HOURS disease or condition resulting in death) /Medical Examiner UCTIVE PULMONIARY DISCASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner signed by the attending physicien and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 € No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LIVER CIRRITOSIS DUE TO PORTAL HYPERTENSION 1 ¥ Yes 2 □ No 3 Probably 4 DUnknown Completed TRICUSPID REBURGITATION-SEVER 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Fesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. escribe how injury occurred 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00022633

State Registrar

DHMH 17 Rev 1/2001

Towson MD

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

32. Regiotra s Signature

AUG 0 6 2010 Denous B. Jake

110 West Rd building A.

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2010 July Physician/ 19 2130 Pinnock Hainy Oliver **Medical** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Hospital Gaithersburg 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 🕍 1 2 🗆 F Months Hours Jan 10, **1**963 Director Jamaica 577-82-2374 47 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 XYes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 Jamaica 12005 Berry Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Private 10th Construction Worker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leroy Pinnock Rosetta Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12005 Berry Street, Silver Spring, MD 20902 Lumene Pinnock Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7/31/2010 Silver Spring, MD Gate of Heaven 4 Donation 5 Other (Specify) 22. Name and Address of Facility of Funeral Service Licensee Latimore Funeral Services, P.A. 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physiciani LIVER FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner EMBOLISM PULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed RESPIRATORY FAILURE and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the a id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Yes I Minpatient 2 ER/Outpatient 3 DOA 24 hours after death. e Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier

Registrar

30

0

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Regis dar's Sig

BANGALORE

29c. License number

9901 MEDICAL CENTER DRIVE

DOO 67512

29d, Date signed (Month, Day, Year)

JULY

ROCKVILLE MARYLAND

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - State Registrar Certificate of Death 2. Date of Death Physician/ $0^{\frac{Month}{7}} 18 - 20^{\frac{N}{1}} 0$ Ronald Maurice Peterson, Sr. 11:49AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 X M 2 □ F Days Min. 10-25-1946 577-62-6745 DC **Director** 63 Usual Residence of Decedent 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Temple Hills 10e, Street and Number 10g. Citizen of What Country? Funeral 3420 Rickey Ave., 20748 USA #105 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates1 971-73 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 Yes 2 No Specify Specify: Black "natural", 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Computer Programmer Dist. of Col. Gov't Be - snould be file th and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mack C. Peterson Crecia Raiford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Ronald M. Peterson, Jr./son 1449 Potomac Hghts Dr., Ft. Washington, MD 20b. Place of Disposition (Name of corretery, crematory or other place)
MD Veterans Cem. Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any Injury or 07-28-2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 20746 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lyman M01374 May 74 Cedar Hill FH,4111 PA Ave., Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PHEUMONIA Sequentially list conditions, if any, leading to immediate Examir sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death.

I Director: After this d in by the funeral di 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

State Registrar (Check only one)

29b. Signature and title of certifier

PISCATAWAY

750

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC ANTWI-DONKOR SUITE

ROAD,

D0048123

29d. Date signed (Month, Day, Year)

-20-2010

10-05340 Jovon Perry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 24732 State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.					
Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mooth Day Year				1	3. Time of Death	
Medical Exami	ner	00,01 1122-01 1		July 17, 20	10	0036 hrs
		4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Dea Baltimore	ath	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia		Irs. 8. Date of Birth	1982 9. Birt	hplace (State or Washington
Director		579-06-0434 1XM 2_F 27	Yrs. World's Days Hours W	Septem		untry) D.C.
ž:		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location			10d. Inside City Limits
ow any		1.00				1 X Yes 2 No
Aaryland 28a-f show 1 at once.	ţ	Maryland 10e. Street and Number	Baltimore 10f. Zip Code	T ₁₀	g. Citizen of What Coun	
th the Maryland 23a or 28a-f sho notified at once	Director	2927 Rock Rose Avenue	21215	10	United Sta	
vith th		11. Marital Status 12. Was Decedent Ever in U.S		Specify Yes or No-	14. Race - Americ	
eath v item	Funeral	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puel		White, etc.	
fter d		3 Widowed 4 Divorced If Yes 2 No	1 Yes 2 X No specify:		Specify: B	lack
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once.	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use n		16b. Kind of Business/Ir	ndustry
6 n 72 h an "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		etiled)	W	
0036 within 72 giene. her than	m o	11th grade 17. Father's Name (First, Middle, Last)	None	and (First Minds) - NA	None	
21215-0036 sold be filed within 72 hours Mental Bygione. marked other than "natur c event, the Medical Exam.	Be C	William McClough, Jr.	Rowen	me (First, Middle, M a Vendet	·	
2121! 2121! Mental Filmarked	o B	19a. Informant's Name/Relationship (Type, Print) (Mother)	19b. Mailing Address (Street and Number o			Zip Code)
ore, MD ; es 1 and 2 show of Health and 1 If item 27 is 1.		Rowena V. Perry McClough	1412 Buchanan Stree			
e, F l and Healt item		20a. Method of Disposition 20b. P	lace of Disposition (Name of cemetery.		20c. Location - City or	
imore, MD 2 Pages 1 and 2 shoument of Health and N ant: If item 27 is n or other traumatic		1 23 Buriar 2 Ordination 5 Removal from state	yland National Memori			vland
Baltimore permit. Pages 1 a Department of He Important: If it	ŀ	21. Signature of Funeral Service Licensee	22. Name and Address of Facility R.	N. Hort	on Company	Morticians,
m Pe D		Landiph & Jule	Inc.;600 Kennedy	Street,N.	W.;Washing	ton,D.C.20011
Physician		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Gunshot Wound of Necl				Death
	- 1	or condition resulting in death) Due to (or as a consequence of)	:			
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)	:			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in leath). Last				
nted d ansit		events resulting in death) Last Due to (or as a consequence or)				
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760, ficate be g physici the bun	Mec	IF FEMALE: 23c. If yes, outcome of pregn			23d. Date of delivery	
	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ectopic preg	nancy	Month Da	ay Year
Box 68 death certifi the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)		1	4
O. B. It the de by the ached f		Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
ires that the signed by	ap			1 Yes	2 No 3 Proba	ably 4 Unknown
required been hould	Completed			24a. Was ar autops		opsy findings available ompletion of cause of
ecol ne law te has	티			perform	ned? death?	_
tal Rectian: The certificate ector, page	Ö	25. Was case referred to medical	26.Place of Death (Chec		10 10	
Vita hysicia this ce	OB O	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 V I	ER/Outpatient 3 DOA Other 1 Nurs	sing Home 5 R	esidence 6 Other:	
Division of Vital Records, P.O. Box 68 tall or Attending Physician: The law requires that the death cert is after death. al Director: After this certificate has been signed by the attendinted in by the funeral director, page 2 should be detached for use as	ī.	(Month, Day Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe ho Subject shot	w injury occurred	
[환호 g 로 Q.	atio	1 Natural 5 Pending Jul 17, 2010	0001 hrs 1 Yes 2 ✓ No	Subject shot		
ivis lor A after of Direction by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At hor	ne, farm, street, factory, office building, etc.	or Town, Sta	reet and Number or Rurate)	- 100-1
D spital hours neral		4 Homicide determined (Specify) Sidewalk 29a. Certifier 1 Certifier Physical Table 194		3800 Park Heig	hts Avenue, Baltimo	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical	one) 2 ✓ Medical Examiner: On the basis of examination and				
To t with. To tl	Med	and manner stated. 29b Signature and title of certifier	29c. License number		29d. Date signed (Moni	
	O.C.M.E. July 17, 2010					
	-	30. Name and address of person who completed cause of death (Item 2			,, 20.0	
		Victor Weedn MD JD Assistant Medical Examine	·	D 21201		
St	ate				-	
Regist	rar	31. Date filed Month, Day Year) 32. Registrar's Signature	factor			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20ay **Physician** Clarence Leroy Ross 2010 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Regional Prince George's Laurel aure. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours Min. 1**⊠**M 2□ F Yrs 579-30-1311 83 June 9, 1927 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 13205 Clarington Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: African þ 3 Widowed 4 X Divorced Year or Dates American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Civil Engineer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alberta Robinson Nelson Ross, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Ross/ Daughter 3428 Londonleaf Lane Laurel, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, July 2010 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 20019 4001 Benning Road NE Washington, DC Approximate Interval Between Onset and Death 23a. Part Lener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Pulmonary Disease Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Box 68760. attending pl P.O. been signed by the should be detached Division of Vital Records. cate has by page 2 sl certificate ours after death.

neral Director: After this certific filled in by the funeral director,

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Model Examine Is as the restitled at any Injury or other traumatic event, the Model Examine Is as the restitled at any Dines.

Physician /Medical

Baltimore, Maryland 21215-0036

Certification: To Medical

24 hours a within 24 hor To the Fune completely fi

> State Registrar

3

29b. Signature and title of certifler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Munim,

6 ☐ Could not be

29c. License number D55861

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

July 20, 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospita Regional durel

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State
 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20, Day 2010 ear July Joseph Spirer 7:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1801 East Jefferson Street, #638 Rockville Montgomery If Under 1 Year I If Under 24 Hrs 6. Sex Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Hours Min. 09/02/1913 New York 080-20-0552 **Director** 96 Usual Residence of Decedent 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1X Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1801 East Jefferson Street, #638 20852 Page 1 and 2 should be filed within 72 hours after death verter of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2K No Specify: White Specify 3 X Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Julius Spirer Sadie Struhmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julian Spirer, son 7920 Maryknoll Avenue, Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot star of David of the Palm Beaches 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 07/21/2010 West Palm Beach, Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, MO1255 1170 Rockville Pike, Rockville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Gastric Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pneumonia 1 Tes 2 3 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN certificate 2 No 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c}\) Residence 6 \(\sum \) Other (Specify) 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Virtin 24 hours and within 24 hours and To the Funeral Director: After analytical filled in by the fur 1X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 7/2009

10

6121 Montrose Rd,

32. Registrar's Signature

R172412

Rockville, MD 20852

alyson Temen (RNP

Alyson Timlin

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

7/20/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RegistraMFND#23a(a/b)perMD7/28/10,BWW,McCo Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 July 20 Herman I. Shaller 11:01 p^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Arden Courts Assisted Living Kensington Montgomery 7. Age (In yrs. last birthday) **Funeral** Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birtnpis-Country) 1 🖾 M 2 🗆 F Days Hours 01/24/192 89 Director 089-16-6493 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No MD Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 7620 Old Georgetown Road #732 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced WWII Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ US Government Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental I ဂ္ Frances "unknown" Morris Shaller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7620 Old Georgetown Rd, #732, Bethesda, MD Cora Shaller, wife 20814 item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place, 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns 07/22/2010 Olney, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses EDWARD SAGEL FACTOREAL DIRECTION, INC. MO1477 1091 Rockville Pike, Rockville, Maryland 20852 25. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line PNEUMONIA Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to TEMECRIFF THE CONTROL OF Examiner Alzheimers Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed^a death? certificate 2 🔀 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted

4 Nursing Home 5 Residence & Other (Specify) Living 2 **X**No Other: မှ 1 Yes within 24 hours after death.

To the Funeral Director: After this and annual eta funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nursa Practioner: To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. D27660 10 21

Registrar
DHMH 17 Rev 7/2009

State

Alpana Goswam M, MD, 11125 Rockville Pike, Suite 110, Rockville, MD

20852

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland /		artment of F <i>tificate of D</i>					
			Registrar 1. Decedent's Name (First, Middle, Last)		-007	timodio or E	- Cutiii	2. Date of Dea		10 3.4	ime of Death 6
	ıysicia Medio		Doris	E	Se	ee			Jul 3	<u>31, 2010 `</u>	ear 3	:00 AM
; E	xamin	er	4a. Facility Name (if not institution, give s 632 Hilltop Drive					Location of Death erland		4c. County of Allec		
Fu	neral		5 Social Security Number 6 Se	7 Age	In yrs. last bii	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	n 9	9. Birthplace (State or Foreign
	ector		210-12-0221	M 2 □ x	86	Yrs.	Months Days	Hours Min.	Jan 1	0, 1924	Country)	1D
and	show Lat	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow						10d. Ins	side City Limits
Maryla	28a-f	irect	MD Alleg	any		Cui	mberland				1	∐xYes 2 □ No
th the	3a or t be n	al D	10e. Street and Number				10f. Zip Code	04500		10g. Citizen of Wh		·
ath wi	ems 2 r mus	Funeral Director	632 Hilltop Drive	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	21502 spanic Origin? (Spe	ecify Yes or No-	т	JSA American Ind	ian.
fter de	or it		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 N If Yes, Give	0	- 1	Yes, specify Cubar	n, Mexican, Puerto Specify:	Rican, etc.)	Black,	White, etc.	
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene.	atural cal Ex	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed	Year or Dates.	16		ent's Usual Occupa			Specify:	white	9
215 in 72 h e.	an "n Medi	dmo	(Specify only highest grade Elementary/Seconday (0-12)			(Give k	ind of work done d NOT use retired)	uring most of work	ing	16b. Kind of Busin	ness industry	
d with	nt, the	Be C	12 17. Father's Name (First, Middle, Last)			<u>trust</u>	officer			bank		
lan(be file	marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	입	Benjamin See					18. Mother's Nam		(Linn) Se	e White	ehair
Maryland 21215-0036 2 should be filed within 72 hours after this and Mental Hygiene.	traumatic		19a. Informant's Name/Relationship (Type			b. Mailin	g Address (Street a	nd Number or Rura	al Route Number	City or Town, Stat	e, Zip Code)	
	other tr		Karen Goetschiu 20a. Method of Disposition	s nied			9 Hilltop I			mberland	MD	
~ U v	Marson		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemete	ery, crem	natory or other place norial Ceme	9) :	Date 8/3/2010	20c. Location - Ci	erland	MD
Baltimore, bermit. Page 1 and Department of Hea	any injury or once.		21. Signature of Funeral Service License			22.	Name and Addres	s of Facility elli Funeral H	lome, PA	0 411110		
u ā0.	<u> </u>		23a. Part 1/. Enter the disease, or comp	inations that caused t	ne death Do		108 V	<u>irginia Avenu</u>	e: Cumber	land, MD 215	7	
Physi			shock, or heart failure. List only on Immediate Cause (Final		L	M	1	,	or respiratory arr	551,	Interv	oximate val Between t and Death
Me	dical		disease or condition resulting in death)	Due to (or as a	equence	of):	Depredio	parky			6	mo-5
LAdi	IIIIIei	e.	Sequentially list conditions,	o. — Due to (or as a c	- Barnerou	- No						
uted	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	200 10 (5) 49 4 (
/ 6U cate be executed physician and	urial-tra		that initiated events resulting in death) Last	Due to (or as a	consequence	of):						
750 cate be	the bu	edical		d		· · · · ·						
Certific	use as		Low trad according program.	3c. If yes, outcome of	pregnancy	h a 🗆	Ectopic pregnance			23d. Date	of delivery	
Goa th of the after	should be detached for use as the burial-transit	Physician/N	in the past 12 mooths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at t	me of death		Other (specify)	у		Month	n Day	Year
that the	detach	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	ute to the caus	se of death?
dS, I quires t	uld be								1 🗆 1	es 2 🗆 No 3	Probably	4 🗆 Unknown
Kecords, The law requires	e 2 sho	Completed							24a. Was a autop	sy pric	or to completic	dings available on of cause of
n: The	or, pag		25. Was case referred to modical				06 PI-		1 Yes		th? Yes 2 1	No
VITAI iysician: is certific	directo	To Be	examiner?	lospital: 1	t 2 🗆 ER/O	utpatient	_ Othe	r: 4 Nursing Ho		ence 6 🗆 Other (Specify)	
ing Pt	uneral		27. Man of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,		Time of injury	28c. Injury work?	at ?		ow injury occurred		
or Attendir after death. Director: Af	oy the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	- At home, fa	arm, stre		Yes 2 No	28f. Location (S	treet and Number o	or Rural Route	Number.
LIN after all or all Dire	led in t		4 El Fiornicide determined	building, etc. (Specify)				City or Tow	n, State)		
DIVISION Of VITAL RECORDS, F.O. BOX To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. With Instruction of the principle of the this certificate has been signed by the after	completed filled in by the funeral director, page 2	Medical	(Check 2 Medical Examin	cian: To the best of m er: On the basis of exa Practioner: To the be	mination and/	or investi	gation, in my opinior	n, death occurred at	the time, date ar	nd place, and due to	the cause(s) a	and manner stated.
To the To the	сошо		29b. Signature and title of certifier	Practicular, no the be	St Of Hily KHOW	vieuge, u	29c. License			29d. Date signed (A		ear)
			· ////	Vagni	res	M)22	181	Angus	+2	2010
			30. Name and address of person who co	mpleted carse of dea	th (Item 23a)	(Type, Pi	Int)	SH DON	E Clin	vatorin	n Ain	N 21502
	Stat	_	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	الدال	UF WITH	WII UKI	ic, cm	HILL	114011	IN CION
Re	gistra	ır	AUG 0 6	2010 Dan	wa	3.	Barke					

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

68760

Division of Vital Records,

10-05662 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joseph Lewis Taylor, II 1- For State Certificate of Death Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Deat Physician/ Month Day July 28, 2010 1916 hrs **Medical Examiner** Joseph Lewis Taylor, II 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 38508 Arlington Drive Mechanicsville St. Marv's 5, Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral oreign Cheverly. Months Days Hours Director 214-06-9304 39 February 11, 1971 Country) Mary land 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 X Yes 2 No narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. Maryland Anne Arundel Glen Burnie es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1027 Sharon Drive 21061 USA 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. Never Married 2 Married 2 X No Yes White Specify: 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Technology Specialist Computer 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Lewis Taylor, I Rosemary Elizabeth Connors 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Lewis Taylor, I / Father 16 North Gail Street, Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 7/31/2010 Alexandria, Virginia 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Dilated Cardiomegaly Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner

Division of vital Necolus, P.O. Box 887 80,	To the Hospital or Attending Physician: The law requires that the death certificate be executed		To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	
DIVISION OF VITAL	To the Hospital or Attending Physician:	within 24 hours after death.	To the Funeral Director: After this certifi	completely filled in by the funeral director,	

Sequentially list conditions,	b						
if any, leading to immediate Due to (or as a consequence of):							
cause. Enter Underlying Cause	c.						
events resulting in death) Last	Due to (or as a consequence of):						
	d			1			
X UNPENDED	☐ AMENDED 23a,pt.II, 2	27 per me g906 8-9-	-10 vt				
IF FEMALE:	23c. If yes, outcome of pregnancy		23d. Date of delivery	,			
23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3 Ectopic pregn	ancy Month D	Day Year			
	4 Pregnant at time of death 5	Other (Specify)	1				
1 Yes 2 No 9 Unkno	own 9 Unknown		- 7				
Part II. Other significant condition	ns contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?			
Tumnal Camana	was Ambanya		1 Yes 2 No 3 Prob	pably 4 Unknown			
Tunnel Corona	ry Aftery			7 (23			
1				topsy findings available completion of cause of			
			performed? death?	completion of cause of			
			1 Yes 2 No 1 Yes	es 2 No			
25. Was case referred to medical		26.Place of Death (Check	only one)				
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Other Nursi	ng Home 5 Residence 6 🗸 Other	r: Scene			
27. Manner of Death	28a. Date of Injury 28b. Time (Month, Day, Year)	e of Injury 28c. Injury at Work?	28d. Describe how injury occurred				
1 X Natural 5 Pending		1 Yes 2 No					
2 Accident Investig				15 (1)			
	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
4 Homicide determin	ned (Specify)						
29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, death of	occurred at the time, date and place, and	d due to the cause(s) and manner as state	ed.			
	ner:On the basis of examination and/or inves						
	and manner stated.						
29b. Signature and title of certifier		29c. License number	29d. Date signed /Moi	nn. Dav. rean			

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 29, 2010

State

Registrar

32. Registraj

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

AUG N

31. Date filed (Month, Day Year AUG 0 3 2010

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7-18 - 2010 ear Physician/ Ollie Mae Williams 2:23 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours 1 □ M 2 X F (Month, Day, Year) 0-06-1927 340-24-7133 Director 82 Usual Residence of Decedent In than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince George's Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? Funeral 13220 Fox Bow Drive, Apt. 20774 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or any injury or other traumatic avant the state of the s þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Black Specify: Completed 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 t h College (1-4 or 5+) Factory Worker Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Doveeye Westfield Cobb Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacquelyn Williams/daughter 13220 Fox Bow Dr., Apt. 102, Upper Marl., MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Cedar 07 - 23 - 2010Hill Cem. Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wary MO1374 Cedar Hill FH,4111 PA Ave., Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, If any leading to in realist cause. Enter Underlying Cause (Disease or iinjury Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes after death.

Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မြ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i the Hospital 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion structure. Medical (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

ddress of p

Registrar

AWHAM, MD 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Month Girma Yigezu 7:00 PM Ju1vMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Ethiopia 1 🛛 M 2 🗆 F Hours (Month, Day, 577-82-1098 Director 55 November Usual Residence of Decedent or 28a-f shov ral", or items 23a or 28a-f shor Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's College Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9352 Cherry Hill Road 20740 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black "natural", 3 Divorced 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) University of Maryland and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Center Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Yigezu Kidane Tsige Wolde Gabriel permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hirut Taye / Wife 9352 Cherry Hill Road, College Park, MD 20740 or other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 7/17/2010 injury o 4 Donation 5 Other (Specify) Brentwood, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 any Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RTHERZOSECUROTEZ Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of). ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral 27. Manny of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State

٥

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 2 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Don Michael Coleman, II, 7600 Carroll Avenue, Takoma Park, MD 20912

29c. License number

29d. Date signed (Month, Day, Year)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Dep Registrar Ce	artment of Health and rtificate of Death		ne N2 0 1 0	24742	
a			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
40	Physici /Medio			arus	July 2	0 2010	3:06 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Deat Baltimore City	h '	4c. County of Death	1	
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs Months Days Hours Min		arl Con	nplace (State or Foreign Intry) nsylvania	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits	
	Maryland a-f show fled at	ctor	New Jersey Atlantic Atlan	tic City			1X Yes 2 □ No	
	or 28 e noti	Director	10e. Street and Number	10f. Zip-Code	10g.	Citizen of What Cou	*	
	sath w	eral	37 S. Spray Avenue	08401	No acif a Maria a Ma	United S		
920	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 X No Specify:	opecity yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: W		
2-0	72 hor	eted	(Specify only highest grade completed) (Giv	edent's Usual Occupation be kind of work done during most of wo	rking	b. Kind of Business/I	Industry	
2121	d within giene. rr than "i	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired) ecretary/Treasure	r Ur	nion/Loca	1 54	
Maryland 21215-0036	4 2 a s	To Be (17. Father's Name (First, Middle, Last) Samuel Masteroff	18. Mother's Na EVa	me (First, Middle, Mail Spiege I	den Surname)		
≥	es 1 and 2 should to of Health and Ment fitem 27 is marked rother traumatic		19a. Informant's Name/Relationship (Type. Print) Karen DeVito, Daughter 19b. Mai 37 S	ing Address (Street and Number or R Spray Avenue, A	dural Route Number, Cit tlantic Cit	ty or Town, State, Zi	ip Code) 8 401	
Baltimore,	Pages 1 a nent of Hee int; If item iry or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition cernetery, cre	osition (Name of of omatory or other place) Memorial Park 07,		Location - City or T		
altil	permit. Pages Department of Important: If it any injury or o once,							
n	8 9 E 8 9	1 10	MOIDOS 2	orchinsky Hebrew 1 4 Carroll St., N	W. Washingt	ton, DC	20012	
_		5 79	23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):					
	Examiner		Sequentially list conditions, b.		+ //			
	g O t	Examine	if any, leading to immediate Due to (or as a consequence of):					
	be executed cian an Surial-transi	Exar	Cause (Disease or Injury that intitated events resulting in death) Last C. Due to (or as a consequence of):	at initiated events c				
3/60,	icate be executed physician an s the burial-transi	edical	d					
õ			IF FEMALE:					
X DO	ath ce attendi for us	Physician/M	23b. Was decedent pregnant in the past 12 mg/ths? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver Month	very Day Year	
5	the de y the a	hysi	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown					
as, r	The law requires that the death certif the has been signed by the attending page 2 should be detached for use a	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to		
Hecords,	w requ	Completed			24a. Was an	24b. Were aut	opsy findings available completion of cause of	
Ĭ	F age	Com			autopsy performed′ 1 ☐ Yes 2 🗹	? death?	2 No	
N I I	sician: Th certificate lirector, par	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other:	ath (Check only one)			
5	Physic ruthis caral dii	5	27. Manner of Death 28a. Date of Injury 28b. Time of Death	of 28c. Injury at	lome 5 Residence		fty)	
SION	nding ath. r: After	atio	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No				
<u>"</u>	al or Atte s after de I Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place avestigation, in my opinion, death occurred	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
						Date signed (Month,		
	7		P (UCor	RES-000	Ju	dy 20, 2	010	
			30. Name and address of person who completed cause of death (Item 23a) (Type Pr. Rory Goodwin		North Wolfe	St. Baltimo	re, MD, 21287	
Į	Stat	J	31. Date filed (Month, Day, Year) 32. Registrar's Signature				,, - 1201	
	Registra	1	. IIII 2 3 2010 B A Cont					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

and burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the a page 2 s certificate director, After thi

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 29 Day 2010 July 11:15 A^{M} Ann Beckner /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 12905 Cunninghill Cover Road Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1937) Oct /, 1937 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🖾 F New Jersey 72 213-34-8463 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ?7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the "Nedical Eventine distant to notified at Baltimore 1 Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 USA 12905 Cunninghill Cove Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) 1 2 College (1-4or 5+) bookkeeper landfill permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygii Important: If Item 27 is marked other i any injury or other traumatic event, Ib 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Leo Long Gretchen Eileen Paquet 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 32 Bee Tree Mill Drive; Parkton, Maryland 21102 Charles Beckner - son 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Othey (Specify) 22. Name and Address of Facility State Anatomy Roard 21. Signalure of Funeril rivice Licensee Ronald S - Was 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) **Physician** renal all cancer netastatic MUS. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40850 30. Name address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date ived (Month, Day, Year)

AUG 0 9 201

OTTALLAND

32. Registrar's Signature

9103 Franklim Square Dr Bultimo MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1846PM 100 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins
5. Social Security Number Itimore Medical (If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Min. Hours 0872971913 Mary land 96 Yrs. Director 216-10-2669 Usual Residence of Decedent 28a-f show 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 Candry Terrace 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 Married 1 XX/es 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Specify: White 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) filed within Production Worker Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filk tment of Health and Mental I tant: If item 27 is marked o 2 John Henry Brehm Minnie Loeffler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie M. Grupp (Daughter) 9548 Hallhurst Road, Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 108/09/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Bruzdziński Funeral Home,
1407 Old Eastern Avenue, Essex, P.A. Maryland 21221 23a. Part 1. Jet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sho, or heart faili Physician/ dis se or condition resulting in death) and Medical Due to (or as a consequence of): Examiner 2098 Shu Sequentially list conditions, Examine Due to for as a consequence off: cause. Enter Underlying signed by the attending physician and Id be detached for use as the burial-transit 10(a/d) Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No g Unknown g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISCUSC Division of Vital Records, obstructive 1 Yes 2 No 3 Probably 4 Unknown to the runeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 2 🔽 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b, Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death, Natural 5 \square Pending work? injury 2 🗌 No 2 Accident
3 Suicide Investigation 24 hours after death Funeral Director: 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Certifying Nurse Practions. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29c. License number ٥ 29d. Date signed (Month, Day, Year) Res-00 30. Name and address of person who comp etect cause of death (Item 23a) (Type, Print) Ave, Baltimore 4940 enlamin Petre MI 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24745 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Aug 8, 2010 Year Melvin Davis Bright 8:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale **Baltimore** 5100 Cynthia Ct. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days nth, Day, Year) Apr 17, 1951 1 M 2 🗆 F Months 217-54-2648 59 MD Yrs. Director Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Completed by Funeral Director Rosedale MD **Baltimore** 1 🗆 Yes 2 🗖 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21206 5100 Cynthia Ct. U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. 3/3/1973 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣No Specify: 9/22/1975 Specify: 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Repairman Labor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Russell Bright Sr. Alice J. Hurley 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 1337 Willow Rd. Dundalk, MD 21222 Scott D. Bright Son item 2 20a. Method of Disposition
1 ☐ Burial 20 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory, LLC permit. Page 1 Department of Important: If it any injury or o Aug 10, 2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 re of Funera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition "ULMONAR" Physician/ OBSTRUCTIVE DISEASE CHRONIC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year detached for Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LUNG CANCER Records, 1 Tes 2 No 3 Probably 4 Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No ☐ Yes 2 🔀 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital: Other: 뎯 2 **5**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injun 1 Natural 5 \square Pending work? 2 🗆 No 2 Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my inowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse practicines: of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi Gertifying Nurse Fractioner: To the best of my knowledge, dust honoured at the time. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 038631-57 cause of death (Item 23a) (Type, Print)

Print)

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Print)

Print)

Print)

Print)

Print)

Print)

Print)

Print) Name and address of person who complete AUAR KISHORE UDY. 31. Date filed (Month, Day, Year) State Registrar AUG 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUL Y 8.47 AM Robert Leroy Brooks, Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Days Jan. 31, Year 53 Months Hours Min Marÿliand 214-64-7441 Director 57 Yrs Usual Residence of Decedent or 28a-f shoven 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Baltimore 10e Street and Number 10f. Zip Code ö 10g. Citizen of What Country? items 23a or ner must be r by Funeral 21207 United States Ct Duke Of Windsor Apt 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner n 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced Completed White 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10th Home Improvement Commission Carpenter-Contractor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Robert L. Brooks.Sr Marv Alice Basler 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua R. Brooks/Son B642 Clarenell Road, Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory, LLCAug. 1,2010 Glen Burnie, Maryland gneture of F eral Service License 22. Name and Address of FacilitAMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Road, Baltimore, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final MYO CARDIAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially flet conditions Be Completed by Physician/Medical Examiner if any, leading to Immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year 1 Yes 2 9 Unknown should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital Other: 1 🔲 Yes 2 🗷 No Certificate: To 1 Inpatient 2 R/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending death. Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 24 hours after of Funeral Direc determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29b. Signature and title of certifier 27,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57 MARLES CURTIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G906, 8/9/2010, WS

State of Maryland / Department of Health and Mental Hygiene 24747 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2125 Bush Deloces 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** North west Hospital ER1 Randallstown Bultimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 F Months Days Hours Min. Yrs. 212-48-2192 11/11/1947 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f show Examinar must be notified at 1 ☐Yes 2 No Director Baltimore Baltimore MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 21207 Funeral <u>3905 Essex Road</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐Yes 2 ☐No Specify ð 3 Widowed 4 Divorced "natural", Completed 7 is marked other than "natur traumatic event, the Wedland 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of MD Social Worker 2 12th yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Tucker Pameroy Bush မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Essex Road Baltimore, MD Barbara Irving-sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages Department of Important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/8/10 Woodlawn, MD Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue March FH West Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Winam 21215 Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner shock Septic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed complications 0+ Metastatic attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) the 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? pade 2 s autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Attending Physician; 25. Was case referred to medical examiner?
1 ☐ Yes 2 No director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident the 1 Director; 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ò within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D\$668783 07/01/2010 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. deWit MD. Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes 24748 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frederick James Bowie, Sr. August 2010 8:17A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3302 Hawks Hill Road Carroll New Windsor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 □ F Days Hours 95 Director 096-09-2127 16, 1914 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Exercitor roust be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 XNo Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 3302 Hawks Hill Rd. 21776 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Armed Forces:
1 Teles 2 No
If Yes, Give
Year or Dates: 1942-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) or and 2 should be filed within of Health and Mental Hygiene. private Elementary/Secondary (0-12) College (1-4or 5+) 9 dental technician dental practice 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ James A. Bowie Amanda Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other to Frederick J. Bowie/son 6684 Springford Terrace Harrisburg, PA 17111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 8/3/2010 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home atharine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications the car'sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nmin /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 1 □ Yes 2 **A**No 2 □No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending In 24 hours are: the Funeral Director; A investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number cause of death (Item 23a) (Type, Print) d address of person who

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc g906 8-10-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Z Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wilbur Bellamy OS Month Physician/ 0449 A-M Ther Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Secours Baltimore NA 6. Sex 1/1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) SC **Funeral** Months Hours Min (Month, Day, Year) 247-48-131 76 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2757 Winchester Street 21216 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. African 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American "natural", 3 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Locke Elementary/Seconday (0-12) College (1-4 or 5+) 9th Grade NΑ Machine operator Insulators Inc Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willie Bellamy Elvy Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2757 Winchester Street Baltimore, MD 21216 Emma Bellamy-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State King 08-09-10 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility wylie Funeral Home P.A. Street Baltimore, MD 21217 Signature of Funeral Service Licer 638 Gilmor N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myocardia Fnysician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a so is squence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 🗆 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifler (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Aftending 29b. Signature and title of certifier D0063565 81 151 clan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bon Secours Hospital Benn-M.D. ompson

State Registrar 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 24750 State of Maryland / Department of Health and Mental Hygiene

layton Blumens	1	1- For State Certificate of Death		. No.				
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death			
ical Exami	ner	Clayton Blumenstock	July 26, 20	10	2240 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1829 Aliceanna Street Baltimore	1	4c. County of Deat	h			
		5. Social Security Number un & Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	B Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or			
Funeral Director		1 M 2 F 71 Yrs. Months Days Hours Min	Nov 13	(MM/DD/YYYY) 9. Bi Forei 1 Q 3 R C	grunk ountry)			
	1	Usual Residence of Decedent	NOV 13	, 1930				
any		10a. State MD 10b. County 10c. City, Town or Location Baltimore			10d. Inside City Limits			
and show					1 X Yes 2 No			
Maryland 28a-f show	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry?			
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f sho rent, the Medical Examiner must be notified at once.		1829 Aliceanna Street 21231	- seifu Van es No	USA	rican Indian, Black,			
ath will	Funeral	11. Marital Status unk 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? Unk 13. Was Decedent of Hispanic Origin? (S		White, etc.	ricari filolari, biack,			
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5-0036 led within 72 hours after itygiene. other than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done unk	16b. Kind of Business	/Industry un k			
6 172 hc sn "nı	활	Elementary/Secondary (0-12) College (1-4 or 5+)	1100)					
withir see.	티	unk unk 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name	- (First Middle M	aiden Surname) un	k			
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	17. Fatner's Name (First, Middle, Last) CTTA	5 (1 11 or, 11 11 and 15) 11					
212 212 ould be Ment mark	라	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Numb	per, City or Town, Stat	e, Zip Code)			
MD d 2 should be and n 27 is a umatic		Baltimore Police Department 601 E. Fayette Stre						
re, s l and f Heal If iten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State			
imo Page ment c		4 Donation 5 X Other Specify: in State	- t A t-	amer Doored				
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumatic event, th		21. Signature of Funeral Service Licensee Ronald S. Wade Darector 655 W. Baltimore	Street:	ошу воага Raltimore	, MD 21201			
✓ Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval			
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease			Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):						
	_	Sequentially list conditions, b. If any leading to immediate Due to (or as a consequence of):						
	Examiner	if any, leading to immediate cusse. Enter Underlying Cause (Disease or injury that initiated						
sd sait	Xar	events resulting in death) Last Due to (or as a consequence or):						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	cal	d. UNPENDED AMENDED						
60, ate be e hysicia e buria	sician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ery			
687 ertifica ding pl	an/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn	ancy	Month	Day Year			
Box 6876 e death certificate the attending phy ed for use as the l	/sici	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown						
D. B trthe d by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?			
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Vital Records, ysician: The law requir his certificate has been s director, page 2 should	lete	<u></u>	24a. Was a autops	sy prior to	autopsy findings available completion of cause of			
ecc he lav ate has	티		perform					
al R	BeC	25. Was case referred to medical 26.Place of Death (Check examiner?						
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	To	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursi		Residence 6 🗸 Oth	er: Scene			
n of ding Pl h. After funera	en:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	ZBG. Describe II	low injury occurred				
ISIO Atten r deatl ector: by the	cati	2 Accident Investigation 2Be, Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	street and Number or I	Rural Route Number, City			
Division of N Division of N To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, Si	tate)				
29a. Certifier (Check only (Ch								
Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the								
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (M July 27, 2010	поніп, рау, теаг)			
+NI, W								
	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201							
	tate	31 Date filed (Month, Day Year) 31 Registrar's Signature						
		AUG 0 9 2010 Dear B. Carles			OCMF.			

10-05627

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

illiam Henry E	oi Ovv	1- For State Certific	cate of Death		eg. No. 2011	2475	
Physici			•	Date of Dea Month	Day Year	Time of Death 1522 hrs	
edical Exam	iner	William Henry Brown 4a, Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deal	July 27, 2	4c. County of Death		
		2023 Singer Road	Joppa		Harford		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi			rth(MM/DD/YYYY) 9. Bir Foreig		
Director		215-30-3109 1½M 2□F 76	Yrs. Months Days Hours Mi	June 2	0, 1934 co	untry) New York	
n y		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits	
nd show a	7	MD Harford Joppa	i			1 Yes 2 X No	
/aryla 28a-f∷ 1 at on	Director	10e, Street and Number	10f. Zip Code	1	0g. Citizen of What Cour	ntry?	
h the l 3a or		2023 Singer Road	21085		USA		
ath wit tems 2 st be n	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces?	13. Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puert		14. Race - Ameri White, etc.	can Indian, Black,	
her de: ", or i		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: blac	k	
ours al atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/I	ndustry UNK	
36 in 72 h han "n iscal E	Completed	Elementary/Secondary (0-12)	maintenance	illi ed /			
d with ygiene ther t	Com	17. Father's Name (First, Middle, Last)		ne (First, Middle, I	Maiden Surname)		
215 be file mtal H rked o	Be (John Malvin Brown			th Parrish		
Baltimore, MD 21215-0036 permit: Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	7	19a. Informant's Name/Relationship (Type, Print) Pamela Brown - wife	9b. Mailing Address (Street and Number or 2023 Singer Road; J				
and 2 fealth item 2		20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery,	Date Date	20c. Location - City or		
DOFC ages 1 nt of 1 nt: If i		T Buildi 2 Cremation 5 Removal non state	atory or other place)				
altir mit. P partme porta ury or		21. Signature of Euneral Septice Licensee ROITE Id St. Wage, Director	22. Name and Address of Facility St	ate Ana	tomy Board		
		Som // Well	655 W. Baltimore				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.		or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Self-Inflicted Intraoral Guns Due to (or as a consequence of):	not Wound			Death	
	L	Sequentially list conditions, b.					
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated					
ited d ansit	Examine	events resulting in death) Last Due to (or as a consequence of):					
that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	edical	UNPENDED AMENDED					
760, ficate be g physicist the burn	-51	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy		ancy.	23d. Date of delivery	ay Year	
Box 687 death certific the attending p	sician/I	past 12 months? 4 Pregnant at time of death	Fetal death 3 Ectopic pregnOther (Specify)	iancy	World	ay real	
Bo he deal	Phys	1 Yes 2 No 9 Unknown 9 Unknown	is the underlying an acceptance in Red I	1 220 Did to	obacco use contribute to t	he cause of death?	
P.O. es that the igned by be detacl	چ	Part II. Other significant conditions contributing to death but not resulting Renal Cell Carcinoma	ng in the underlying cause given in Part I.		s 2 ✓ No 3 Prob		
ords, P.C. w requires that as been signed to should be deta	ompleted			24a. Was a		opsy findings available	
of Vital Records, ng Physician: The law require After this certificate has been signed director, page 2 should b	dmo			autop perfor	med? death?	ompletion of cause of	
al Re an: The errificator, pa	ပ္	25. Was case referred to medical	26.Place of Death (Check		2 10 10	2 110	
of Vital Rec ling Physician: The After this certificate funeral director, page	70 B	Tes 2 No			Residence 6 🗸 Other	Scene	
n of ding P h. After		(Month Day Year)	Time of Injury 28c, Injury at Work? UND: 1 Yes 2 ✓ No	28d. Describe I Shot Self	now injury occurred		
Division tal or Attendir rs after death.	icati	2 Accident Investigation Jul 27, 2010 151	5 hrs farm, street, factory, office building, etc.	28f. Location (S	Street and Number or Rur	al Route Number, City	
Div oital or ors after rral Di	Certification:	4 Homicide determined (Specify) Single Family F		or Town, S			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or					
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Ye.)							
	O.C.M.E. July 28, 2010						
	30. Name and address of person who completed cause of death (Item 23a)						
		Victor Weedn MD JD Assistant Medical Examiner 31 Date filed (Month, Day Year) 132 Registrar's Sonature	111 Penn Street, Baltimore, MD	21201			
St Regist	ate	N 1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ale				

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lisa Ann Cook	State of Maryland / Department of Certificate of		201	0 21.75			
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) Lisa Ann Cook	1 N	Reg. No. 2 U	3. Time of Death			
Medical Examine	4a. Facility Name (if not institution, give street and number) 4	c. City, Town, or Location of Death	uly 25, 2010 4c. County of Deat				
Funeral	1501 South Charles Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24Hrs. 8.	Date of Birth(MM/DD/YYYY) 9. Bi	rthplace (State or			
Director	1 M 2 K F 42 Yrs.	Months Days Hours Min.	0/20/10C7 Forei	gn ountry) MD			
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
yland -f show once.		timore City	T	1 Yes 2 No			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1501 South Charles St., 2nd Floor	10f. Zip Code 21 230	10g. Citizen of What Cou USA	intry?			
r items 2		Decedent of Hispanic Origin? (Specify s, specify Cuban, Mexican, Puerto Rica		rican Indian, Black,			
rs after de ural", or uniner mu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	es 2 X No specify:	Specify:	white			
5-0036 ed within 72 hour tygiene. other than "matu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during mos	Usual Occupation (Give kind of work of tof working life. DO NOT use retired)					
5-0036 iled within 72 Hygiene. 1 other than the Medical	17. Father's Name (First, Middle, Last)	sabled 18.Mother's Name (Firs	t, Middle, Maiden Surname)	/A			
21215 buld be file Mental H marked o c event, tf	Dominick Minento	Geraldin	g Lewis				
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. tr. If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by F	19a. Informant's Name/Relationship (Type, Print) Geraldine Minento 15	Address (Street and Number or Rural 01 S. Charles St.,	Route Number, City or Town, State 2nd Floor, Bal	timore MD			
MOFE, Pages 1 and nent of Heal ant: If iten or other tra	20a. Method of Disposition 1 Burial 2 KCremation 3 Removal from State Ardent Cre	r place)	,	·			
Baltimo permit. Pag Department Important: injury or ot	4 Donation 5 Other Specify:			Maryland			
M 링스트를 Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	ne and Address of Eacility PLES L. Stevens F Cast Fort Avenu mode of dving, such as cardiac or resc	e, Baltimore MD	21230 Approximate Interval			
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Head injuries		Between Onset and Death				
/_xammor	or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):						
ted Insit	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Unecessor in fury that in the test		202.44				
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Box 6876(e death certificate the attending phy ed for use as the thysician/Me	past 12 months?	death 3 Ectopic pregnancy	23d. Date of deliver Month	y Day Year			
Box (death co	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown	r (Specify)					
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/IM.	Part II. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?			
Records, The law requires froate has been signage 2 should be			24a. Was an 24b. Were au	topsy findings available completion of cause of			
Division of Vital Records, tal or Attending Physician: The law require star after death. "al Director: After this certificate has been sifed in by the funeral director, page 2 should be ertification: To Be Completed		1	performed? death? Yes 2 No 1 Yes				
Vital I hysician: this certifi al director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check only of Body Other, Nursing Hor		: Scene			
n of ding Ph	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 25b. Time of Injury		Describe how injury occurred				
Division of ital or Attending are after death. The Divector: After the flued in by the function in the function of the functin	Pending Investigation Investig	factory, office building, etc. 28f. I	${ m nk}$.ocation (Street and Number or Ru	ral Route Number, City			
Divis Hospital or A 24 hours after Funeral Dire stely filled in b	4 Homicide determined (Specify) unk	un					
To the Hos within 24 h To the Fur completely	(Check only one) 2 Medical Examiner: On the bast of my knowledge, death occurre and manner stated.						
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mo. July 26, 2010	nth, Day, Year)			
	30 Name and address of person who completed cause of death (Item 23a)		341, 20, 2010				
∬ State	Ana Rubio MD. Assistant Medical Examiner 111 Penn Str 31. Date filed (Month, Day, Year) 32. Rejistrar's Signature	eet, Baltimore, MD 21201					
Registrar	AUG 0 9 2010 August A. August A.	Kel					
DHMH 17 Rev 1/2001	ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOETTA MARIE CLEMENTS JULY 25 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTH ARUNDEL HEALTH AND REHAB ANNE ARUNDEL EN BURNIE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** SEP. 18, 1 □ M 2**XX** F Months Days Hours BATON ROUGE, LA 1930 79 **Director** 466.36.3989 Usual Residence of Decedent 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XX No ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 715 HILLTOP RD 21012 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Specify: WHITE Completed 3XX Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** TEACHERS AID Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **GUY NORMAN** MABEL GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health DAUGHTER 305 C MOUNTAIN RIDGE COURT, GLEN BURNIE, MD 21061 JOAN STRIEGEL permit. Page 1 and. Department of Healt Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Eremation 3 Removal from State BAYVIEW CREMATORY INC JULY 28, 2010 BALTIMORE, MD 4 Donation 5 Other (Specify) re f Funeral Service Lic 22 Name and Address of Facility P.A. REGORY. FINK 101148 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 Enter the dise or heart failure ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deathrediate Cause (Final disease or confider resulting in Ph sician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year signed by the a Id be detached f 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pendina 24 hours after death.

e Funeral Director: A pleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signature ar 29c. License number 30. Name and address of person who completed use of death (Item 23a) (Type, Print) Sw

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			ForState	State of M	larylan	•	artment of			1ental Hy	giene		
			Registrar 1. Decedent's Name (First, Midd	elle I oot\		Cer	tificate of	Death	7		Reg. No.	2010	24756
	Physicia	n/	KEUM SOON CHUN	ule, Lasty						2. Date of De Month AUCUST	atn 3 ^{Day}	2010 2010	3. Time of Death
, ,	Medic Examin		4a. Facility Name (if not institution	on, give street and number)			4b. City, Town,	or Locatio	on of Death	7100001		ounty of Death	
-	į – Zamini		NORTH ARUNDEL HE	EALTH AND REHAB			GLEN BU					INE ARUND	
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Unc	der 24 Hrs. s Min.	8. Date of Bir	th v Year)		nplace (State or Foreign
	Director		213.15.1080 Usual Residence of Decedent	1 □ M 2 □ F	91	Yrs.	111011110	1,100		JAN 19,	1919	- CK	OREA
	ind show at	٥	10a. State 10b. Coun	ty	10c. Cit	y, Town or Lo	cation				_		10d. Inside City Limits
	Maryla 8a-f a tified	Director	MD ANNE	ARUNDEL	GLE	N BURNIE							1 ☐ Yes 2 X No
	a or 2 be no	ΙD	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cou	untry?
	h with	Funeral	7948 CROSS CIRCL				210					KOREA	
	r deat		 Marital Status Never Married 2 ☐ M 	12. Was Decedent Armed Forces?			Vas Decedent of I FYes, specify Cub				14	Race - Amer Black, White	
920	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	3 √ Widowed 4 □ Divorce	If Van Cive A	Ķ ^N O	1	☐ Yes 2☐ N	o Spec	ify:		Sp	pecify: ASI	AN
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and	be filed ental Hy ked oth ic event	10 E	17. Father's Name (First, Milotie	, Lasij			unk	18. MC	otner's Name	e (First, Middle,	Maiden Su	rname)	unk
ary	should be and Ment is marker raumatic e		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailin	g Address (Street	and Nun	nber or Rura	l Route Numbe	r. City or To	wn, State, Zip	
Σ	id 2 sl salth a n 27 i		SE CHUNG			7948	CROSS CREE	K DR	GLEN BU	JRNIE, MD	21061		
ore	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	on 3 Removal from State			sition (Name of natory or other pla	есе)		Date	20c. Loca	ation - City or 7	Town, State
Baltimore, Maryland 21215-0036	tment tant: tant:		4 Donation 5 Other	(Specify)		N HAVEN	CEMETERY		8.5.20	010	GLE	N BURNIE	, MD
Bai	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		21. Signature of Funeral Service		01148	2 2	INREPUNER	RES 9457M HWY SW	體,P.A. / GLEN E	BURNIE, M	D 2106	1	
			23a. Part 1. Enter the disease,	or o olications that cause	d the deatl	h. Do not ente	er the mode of dyi	ng, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between
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		er	Sequentially list conditions,	b. Due to (or de	NO LEGAL	write: of:						-	
	rted J nnsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	•									
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387	ertifica ding pl		IF FEMALE:	23c. If yes, outcome	of pregna	ncv							
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Visi.	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	ld not be 28e. Place of Inj building, et			et, factory, office			28f. Location (S City or Tow		lumber or Rura	al Route Number,
Ö	oital o	ial C											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medica	ng Physician: To the best of I Examiner: On the basis of ng Nurse Practioner: To the	examination	and/or invest	igation, in my opin	ion, death	occurred at	the time, date a	nd place, ar	nd due to the ca	ause(s) and manner stated.
	To th withir To th comp	2	29b. Signature and title of vertif			,omougo, c	29c, Licens			-, a., a das to ti		signed (Month,	
			Belfu	WD			1) 38	195	8		8/3/	2010	
	By		30. Name and address of perso	n who completed cause of o	leath (Item	23a) (Type, P	rint)	4		00	1	- 1.	(1 1000)
	<i>J</i> v		Dale floor (Month, Day, Year)	and the N	ar's Signat	NR CAL	un High	way	15W	oun	1341	me 10	10 21061
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or		4a. Facility Name (If not	t institution, give	tal			BF	1	TORE		July		20(0 County of Death	1
rector		5. Social Security Numb 214.18.9294 Usual Residence of De-	1[х] M 2ПF XX	Age (In yrs. I	ast birthday) Yrs.	If Unde Months	Pr 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da JAN 5,	ay, Year)		iplace (State or For Intry) MD
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-	2	10e. Street and Numbe	r				10f. Z	ip C <i>o</i> de				10g. Citiz	en of What Cou	untry?
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v Firneral		11. Marital Status 1 ☐ Never Married		12. Was Decede Armed Foro 1 Yes 2 If Yes, Give	No No		Was Dece f Yes, sp l □ Yes		spanic Ori n, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		Race - Amer Black, White Specify:	e, etc.
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To B	ă	AUGUSTUS K							V	ΔΤΗΕΡ	INE FRAN	CIS SH	OPERACH	
	-	19a. Informant's Name		/pe. Print)		19b. Mailir	ng Addres	ss (Street a					Town, State, Z	ip Code)
		PATRICIA S	MITH			4923	BROC	KWOOD	RD. B	ROOKL	YN, MD 2	1225		
	ı	20a. Method of Disposi				lace of Dispo	sition (Na	ame of	e) !		Date	20c. Loc	cation - City or	Town, State
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OIICe.		21. Signature of Furner	ØRK FINK	a	MO	F	NK FL	and Addres	HOME,	P.A.	URNIE, M	D 2106	1	
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dical Examiner	EXG	Sequentially list conditi if any, leading to imme cause. Enter Underlyin Cause (Disease or inju- that initiated events resulting in death) Last	ediate ng Iry	с	as a consequal as a consequ									
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Completed		25. Was case referred	to modical						OC Plan	of Deed	per 1□ Yes	formed 2 No	death?	2□ No
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- ⊢	- 1	27. Manner of Death		28a. Date of	Injury	28b. Time <i>a</i>		28c. Injun		ursing riv	28d. Describe			Gily)
i i		Natural 5 2 ☐ Accident	5 ☐ Pending investigation	(Month,	Day Year)	Injury	M		<br Yes 2□	No				
ertification.	Series S		Could not be determined		f injury - At ho g, etc. <i>(Specif</i>		eet, facto	ory, office			28f. Location City or To	(Street and own, State	d Number or Ru)	ıral Route Number,
Medical C		29a. Certifier (Check only one)	Certifying Phy Medical Exam	/sician: To the b iner: On the bas and manne	in of accoming	ston and/ania	Ai Ai	!	-tolon de	-46	are at an atom at the a	a data and	I alago and due	to the course(c)
M	ME	29b. Signature and title	e of certifier	. (3 .	1 1	2	9c. License	e number			29d. Dat	e signed (Mont My , 31 , 212	h, Day, Year)
		P Ala	myran	, Sacras	(, 1	1.0.		KES	, – c	M I		Ju	ly, 31	, 2910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Dorsch Medical Neal 406UST 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL BURNIE GLEN HRUNDEL にろくにる 8. Date of Birth (Month, Day, Year) May 6, 1929 If Under 9. Birthplace (State or Foreign Country) Maryland . Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Days Hours Min. Director 216-24-7586 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code è 10g. Citizen of What Country? must be Funeral 21226 U.S.A. 627 Fern Hill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. n "natural", or iten ledical Examiner r 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Exxon Mobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ John Dorsch Degrafferreid Beulah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn M. Dorsch (Wife) 627 Fern Hill Road Baltimore, Maryland 21226 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 08/10/2010 Brooklyn Park, Maryland Cemetery 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland . Signature of Fun al Service Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ MYOCALDIOZ MARCI disease or condition Medical resulting in death) Examiner TAME CARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Month Year cate has been signed by the s page 2 should be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUO, CAZ 231111-101 HUD MOILE 32. Registrar's Sanature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Season's Hospice Randallstown Baltimore 8. Date of Birth Julianth, Day 28 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year 1929 Hours Min. 1 🗆 M 2 🕮 Maryland Director 214-24-3222 81 Yrs Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 317 South Norris Street 21223 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Negale Myrtle Hadaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Dunkerly - Daughter 112 Doris Avenue, Brooklyn, MD 21225 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Gremation 3 Removal from State Loudon Park Cemetery: 8-6-2010 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 ent . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (r as a co-sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in the cause) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the inversal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **5**00 Other: 1 🗌 Yes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Othe 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 09

of person who completed cause of death (Item 23a) (Type,

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Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NUBERN 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NONTHWEST CONTON MAMOALL BALTIMONT HOSFII STOWN Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral M 2 - F **Director** Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director 13 a Itimore Mills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 Timber Grove Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Employed Janitorial 12th arade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Dube 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) osephine) Timber Grave Doad DWINGS Man 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore 110° 2010 reanmount Crematons Vaughn a. Greene Funeral services Signature of Funeral Service Licenses 22. Name and Address of Facility augh Road Pandallstown MD 21133 iberty 23a. Part 1. Ent if the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fillure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ ATHOMOSCEROTEC CANSTOVASCULAR DISTAST disease or condition Medical resulting in death) Examiner ARATO MYO PATH
Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician; The law requires that the death certificate be executed ONGEST resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death. 24a, Was an autopsy performed? 2 🗆 No 1 🗹 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examine? Other: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Box 68760 Division of Vital Records, P.O. nours after death neral Director: A d filled in by the f within 24 hours a

To the Funeral C

completed filled

Medical

5401 OLD COUNT 31. Date filed (Month, Day, Year) State AUG 0 9 2010

29a. Certifier

(Check

only one)

Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOAD RANDALISTOWN MA 32. Registrar

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, La 2. Date of Death Physician/ Month ڪ 106 38 PM Medical 4a. Facility Name (if not institution, give stre 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ino nium 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? any injury or other traumatic event, the Medical Examiner must be items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married "natural", or 2 🗌 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1945 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life_DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) river Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname, P Informant's Name/Relationship (Typ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of pemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ddress of Pacility a vghn 23a. Part 1. Enter he disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or restratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COLON CANCER Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): ng physician as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery P.O. Box 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No Division of Vital Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 Other: 1 🗌 Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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ALBERT DAUGHTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 26 per verb., g906,08/09/2010dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) of Death Physician/ Medical Facility Name (if no Examiner 4c. County of Death Cama Montgomery If Under 24 Hrs 8. Date of Birth (Month, Day, Ye Social Security Number (In yrs. last birthday If Und 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Months Mary Land 216-58-7954 57 Yrs. Director 1952 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Takoma Park YYes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 United States 8101 Carroll Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ⚠ No
If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Food Service Waitress 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William . Ellis, Jr. Patricia Defoor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8101 Carroll Ave., Takoma Park, MD William Ellis, Jr. / Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/5/2010 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Se ²² Name and Address of Facility Rapp Funeral and Cremation Services 20910 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car, liac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying e Hospital or Attending Physician: The law requires that the death certificate be executed 2.4 hours after death.

2.4 hours after death.

Funeral Director. After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE s, outcome of pregnancy Live Birth 2
Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 4 ☐ Pregnam 9 ☐ Unknown P.O. Part II. Other conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 200 1 Yes Division of Vital 25. Was case referred 26 Place of Death (Check only one) Be examiner? Hospital Other: ျှ 1 🗌 Yes 1 Inpatient 2 X ER/Outpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural 5 \square Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Toleted (Check On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nur within 2 To the e Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only or 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year) 30 Name and 31. Date filed (Month, rar's Signature State Registrar

DHMH 17 Rev 7/2009

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KAREN

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mmy Edwards		State of Maryland / Department of Healing 1- For State Certificate of Death Registrar			2010	2476					
Physicia 'ical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month July 23, 20	Day Year	3. Time of Death 0647 hrs					
			Town, or Location of Death		4c. County of Death Talbot						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Undo Month	er 1 Year If Under 24Hrs. is Days Hours Min.	8. Date of Birth	1963 Sirt						
d 10w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Talbot Easton				10d. Inside City Limits 1 Yes 2 X No					
the Marylan a or 28a-f s	Director	10e. Street and Number 10f. Zip 9538 Black Dog Alley 21	Code	10	g. Citizen of What Cour	itry?					
er death with	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specif	ent of Hispanic Origin? (Spe fy Cuban, Mexican, Puerto F No specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.						
72 hours aft m "natural" al Examine	eted by	or Dates:	Occupation (Give kind of working life, DO NOT use retire		16b. Kind of Business/li	ndustry					
5-0036 ed within Tygiene. other tha	Completed	12 0 homemake	18.Mother's Name (own home						
2121 nould be fill in marked tic event,	To Be		Mildred S (Street and Number or Ru	ural Route Numb							
ore, MC ss I and 2 sh of Health an If item 27 her trauma		Jane Trump - daughter 9538 B1a 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nar crematory or other place)		Date	20c. Location - City or						
Saltimo ermit. Page bepartment mportant: njury or ot	The many large transport of th										
Physician		23a. Nart I. Enter the dise ise, or complications that caused the death. Do not enter the mode of figure. List only one cause on each line.				Approximate Interval Between Onset and					
/Madical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): Biventric	ular Dilatati ar Hypertroph	ion and	Left	Death .					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ar Hypertroph	ny							
uted id ansit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
O, be executed rsician and burial - transi	edical		6 8-27-10 vt		23d. Date of delivery						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spe	_	ncy	100 100 100 100 100 100	ay Year					
P.O. Besthat the degree by the detached f	by Physicia		g cause given in Part I.	23e. Did tol	pacco use contribute to	the cause of death?					
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rate death. The The death After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed			24a. Was a autops perform	sy prior to death?	topsy findings available completion of cause of					
nn: Ti		25. Was case referred to medical	26.Place of Death (Check o	nly one)							
Vita nysicia this ce	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 I	OOA Other Nursing	Home 5 I	Residence 6 Other	:					
ion of tending Ph eath. tor: After the funeral		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	28c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred						
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory (Specify)	y, office building, etc.	28f. Location (S or Town, St	treet and Number or Ru ate)	ral Route Number, City					
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month											
	ž	29b. Signature and title of certifier 29	O.C.M.E.		29d. Date signed (Mo. July 24, 2010	nth, Day,Year)					
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, I	Baltimore, MD 21201								
	hata	31. Date filed (Month, Day, Year) 3. Registrar's Signature									

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 24762 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Leroy Fowler :00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Ellicott City Qa LAReha 10waco CO +1 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 212–40–8190 6. Sex **Funeral** 1 🔀 M 2 🗆 F Days 67 Month Day Year 9/14/42 Director MD Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 🌠 Yes 2 🗌 No 10e. Street and Number 1021 Parksley Avenue 10f. Zip Code 10g. Citizen of What Country? 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 243 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify 3 ☐ Widowed 4 🗷 Divorced Year or Dates 16a Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tree Expert Landscaping Be 18. Mother's Name (First, Middle, Maiden Surname) Stella Kost 17. Father's Name (First, Middle, Last) ပ Leroy Fowler, Sr. 19a. Informant's Name/Relationship (Type, Print)
Ricky Fowler / Brother 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1021 Parksley Ave, Baltimore MD 21223 20a, Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory Date 20c. Location - City or Town, State 7/26/2010 Hanover MD 4 Donation 5 Other (Specify) Victor P. Doda Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore 21. Signature of Funeral Service Licensee)ics 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and D ath Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine end Stake After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Cand Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed^a death? 2 No ☐ Yes 2 ☐ No 1 🗌 Yes the Hospital or Attending Physician: hin 24 hours after death. completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: ဂ္ ER/Outpatient 3 DOA 1 🔲 Inpatient 2 🗆 4 Unursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 1- Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifi 29d. Date signed (Month. Day, Year) 6 0 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who North Ridge 0 000 31. Date filed (Month, Day, Year) State Registrar

After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

-	a		
n/Medica	X UNPENDED A	MENDED 23a,pt.II,27,28a-f per me g906	8-27-20 vt
ž		23c. If yes, outcome of pregnancy	23d. Date of delivery
	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 Ectopic pregnar	ncy Month Day Year
: <u>5</u>		4 Pregnant at time of death 5 Other (Specify)	1
Physicia	1 Yes 2 No 9 Unknown	9 Unknown	
	Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
d by	Cardiomegaly wi	th Moderate Coronary Atherosclerosis	1 Yes 2 No 3 Probably 4 V Unknown
ete			24a. Was an 24b. Were autopsy findings available
힏			autopsy prior to completion of cause of performed? death?
Completed			1 ✓ Yes 2 No 1 ✓ Yes 2 No
اده	25. Was case referred to medical	26.Place of Death (Check o	nly one)
To B	examiner? 1 ✓ Yes 2 No	oital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Other Nursing	Home 5 Residence 6 Other:
	27. Manner of Death	28a. Date of Injury 28b. Time of Injury 28c, Injury at Work?	28d. Describe how injury occurred
흹	1 Natural 5 Pending	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ınknown
S	2 Accident Investigation		28f. Location (Street and Number or Rural Route Number, City
퉤	3 Suicide 6 X Could not be		.08 Friendship Rd. Elkton, Md
Certification	4 Homicide determined	(Specify) house	US Friendsnip Rd. Elkton, Md

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c, License number

O.C.M.E.

Medical

State

Registrar

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

arker

29d. Date signed (Month, Day, Year)

July 26, 2010

1217 hrs

10d. Inside City Limits

1 Yes 2 No

MD 21201

Approximate Interval

Between Onset and

Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	arylan	-	artment of F		and Me	_	2.0	1 0	247	64
	Physici		Registrar 1. Decedent's Name (First, Middle) Milton	fle, Last)		001	Griffin	<u> </u>		2. Date of De	Day	Year 2010	3. Time of 12.35	
	/Medic Examir		4a. Facility Name (If not institution The Johns Hopkin		,	-	4b. City, Town, or Baltimore			J	4c. County		,,,,,	
	Funeral Director		5. Social Security Number 212–34–9906	1 X M 2 T F	ge (In yrs. la 71	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 09/06/	y, Year)	9. Birth Coun	nlace (State or try)	r Foreign
	the Maryland 28a-f show otified at	ctor	Usual Residence of Decedent 10a. State 10b. Count MD BALT	TIMORE		, Town or Lo	cation						10d. Inside Cit	•
	with the a or 28 be noti	Director	10e. Street and Number				10f. Zip-Code	_			10g, Citizen of		itry?	
0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	210 CHESTNUT S 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S No		Was Decedent of H If Yes, specify Cuba 1 Yes 2 XNo dent's Usual Occup	lispanic Origin, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	14. Rac Bla Specia	ce - Americ ck, White,	ACK	
21215-0036	I within 72 liene. r than "nat	Completed		ent's Education lest grade completed) College (1-4 or 5	5+)	(Give life.	kind of work done of NOT use retired	during most	t of workin	g g			r. of	TRANS.
Maryland 2	2 should be filed w and Mental Hygier Is marked other th aumatic event, the	To Be C	17. Father's Name (First, Middle LUTHER JAMES (18. Mothe		(First, Middle	, Maiden Surnai	me)		
Mary	d 2 sho th and I 7 Is ma trauma		19a. Informant's Name/Relation JAMES GRIFFIN/				ng Address (Street 5 TURN BU				er, City or Town		Code)	
ď			20a. Method of Disposition 1X Burial 2 Cremation 4 Donation 5 Other	3 ☐ Removal from State	C	lace of Dispo emetery, crer	osition (Name of matory or other place	(e)	Da	ate 0/2010	20c. Location	- City or To		I.AND
Baltin	permit. Page Department Important; If any injury or once.		21. Signature of Funeral Service		- AKI	• 22	2. Name and Addre	ss of Facilit	y JAN	MES A.	MORTON	& SO	-	
	Physician /Medical Examiner	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CSP and Consumer of the Con	a consequence a consequence	lence (f):	lure Cancer	^					Interval Betwonset and E	
O. Box 687	certifica ding ph use as tl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1	2 🗌 Fetal	death 3	☐ Ectopic pregnanc☐ Other (specify)	у				ate of deliver		Year
J.	w requires that the been signed by should be detact	by	Part II. Other significant condit	ions contributing to death b	out not resu	ulting in the u	underlying cause gi	ven in Part	l.	23e. Did t	obacco use cor res 2 \square No	atribute to t		leath?
Records,	has has	Completed	-							24a. Was autop perfo 1 Yes		Were auto prior to co death? 1 \(\sum \text{Yes} \)	psy findings and properties of completion of	available ause of
Vita	- co	Be	25. Was case referred to medical examiner? 1 Yes	11 a maritaria			. Oth	or:		(Check only o				
Division of Vital	ding Phys h. After this funeral d	tion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	1 Inpatie 28a. Date of Inju ing ing (Month, Day	iry	ER/Outpatier 28b. Time o Injury	f 28c. Injur Worl	4 □ Nui y at	28		lence 6 Otl		<u>/) </u>	
DIVIS	5 # # ⊆	Certification:	3 Suicide 6 Could	d not be mined 28e. Place of injuined building, etc.	ury - At hor c. (Specify,	me, farm, str	eet, factory, office		21	8f. Location (City or Tow	Street and Num n, State)	ber or Rura	al Route Num	iber,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (ing Physician: To the best of al Examiner: On the basis of and manner sta	f examinat									s)
	To the within 2 To the comple	Me	29b. Signature and title of certific	er ;			29c. License				29d. Date signe	ed (Month,	Day, Year)	
		19	20. Name and address of a	-t1 L	dooth (#=	22a\ (T		000)		August	06	2010	
		10	30. Name and address of person HATLM 31. Date filed (Month, Per Year)	HUJAIN			rillil)		600 N	orth Wo	lfe St, Ba	altimoi	e, MD,	21287
	Sta Registr	_	AUG (9 2010 32. Redistra	∪ Oigitali	1. 1	Sarles							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 10

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **GETSLER GLORTA** 2010 а М August 9:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey House Hospice Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months. Days Hours Month, Day, Yea
January 30. 219-28-3247 76 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland N/A South Baltimore 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 1515 Webster Street 21230 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lawson Ford Mary Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Geisler Sr. (Husband) 1515 Webster Street, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park August 9,2010 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 21. Signature of Fusion Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Congestive Onset and Death mmediate Cause (Final Physician/ 5 month isease or condition Medical Due to (or as a consequence of): a-14-, fis Examiner + heamatoid unknown Sequentially list conditions, Examine tan, leading to in reclaticause. Enter Underlying Cause (Disease or iinjury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 📈 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Degeneratua Joint 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ဳ Unknown Records, 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 D Other (Specify) 1+ csp 1Ce 1 🗆 Yes 2 🕱 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural \o`∩™ Division o injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

Harold

Cam

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Teisher

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

14383

29d. Date signed (Month, Day, Year)

Joseph Richey Hospice Baltimore, MD

August 6,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Crystal L. Green 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Union Memorial N/A If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. 1 M 2 F Months Hours Mary land Director 215-88-7150 39 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland | Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a on the Medical Examiner must be Funeral 1 Solar Circle 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stock Person Warehouse other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Unknown Sharon Elizabeth Grier permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4902 Belair Road Baltimore, Maryland 21206 Raymond Grier / Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Atlantic Crematory 08/09/2010 | Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Acensee 22. Name and Address of Facility David J. Weber Funeral Homes PA 1/02 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the ** ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Septic should disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami and I-transit that the death certificate be executed that initiated events Due to (or as a consequence o physician are the burial-t resulting in death) Last Physician/Medical attending philosophers are at the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown detached 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2X No 1 Tes 욘 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 Yes 2 □ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

4:50A M

9. Birthplace (State or Foreign

Black

10d, Inside City Limits

Approximate Interval Between Onset and Death

Dav

1 🗆 Yes 2 📉 No

Box 68760 P.0. Records, Hospital or Attending Physician: The **Division of Vital** within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu

29d. Date signed (Month, Day, Year) 81612010 AT-243 8946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Huspital PAKSAZ, MP 32. Registrar's Sanature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifie

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		•	For State Registrar	Amend #5	, per th	G907	97247 Ce	rtifica	te of L	Death			Reg. No	20	10	24767
ı	Physicia Medic		1. Decedent's Name (Fin Christina	_							1 .	Date of De Month していらう	ath		Year	3. Time of Death 5:55 P M
-	Examir		4a. Facility Name (if not	. ^	1				at	Location of D フカSV:	leath			County		ny o
	Funeral Director		5. Social Security Numb 217 · 20 · 4+ Usual Residence of Dec		7. Age	e (In yrs. la	Yrs.	If Und Months	er 1 Year Days	If Under 24 Hours N		Date of Bird Month, Da	h 1925		9. Birthp Coun	place (State or Foreign try)
	faryland Ba-f show tified at	ector		o. County N/A		10c. City	7, Town or Lo Balt		re						1	0d. Inside City Limits
	with the Ns 23a or 2 ust be no	Funeral Director	10e. Street and Number 3200 McM		1 Avenu	e		10f. Z	ip Code	1216			10g. Cit		/hat Cour	itry?
920	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. artment of Health and Mental Hygiene. rather: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.e.	þ	11. Marital Status 1 Never Married 3 Widowed 4	2 Married	2. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	ver in U.S		f Yes, spe	ecify Cuba	ispanic Origin? n, Mexican, Pu Specify:	(Specity Yuerto Rican	es or No- i, etc.)			- Americ k, White, Bla	
15-0	72 hou n "natu Aedical	Completed	(Specify	only highest grad	e completed)		16a. Deced	kind of w		ation during most of	working		16b. Ki	nd of Bu	siness Inc	dustry
1212	d within ygiene. her tha nt, the l	as I	Elementary/Seconda	le)	College (1-4 or 5	+)	ino. D		mes	tic				Pr	ivate	2
/land	should be filed and Mental Hy is marked oth aumatic event	To B	17. Father's Name (First, Muyray Wi							18. Mother's	Name (Firs			Surname))	
Baltimore, Maryland 21215-0036	ind 2 should lealth and Pour 27 is maker trauma		19a. Informant's Name/	atkins/1			3127	Har	non/	and Number or						
timore	permit, Page 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Dispositi 1 Denation 5	remation 3 🗆 F	demoval from State	~ 0	lace of Dispo emetery, cren	natory or	other place Net 21	nt 108	Date	010	Cro	WNS	ville	wn, State
Ball	permit. Page Department of Important: It any injury or once.		21. Signature of Funeral	Service Licenses	4	\	22		and Addres							Funeral Svc
	Physician/ Medical Examiner		23a. Part 1. Enter the dishock, or heart fail Immediate Cause (Einal disease or condition resulting in death)	ue. List only one	Due to (or as a	consequ	o to C				diac or resp					Approximate Interval Between Onset and Death
	ate be executed physician and the burial-transit	edical Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injur that initiated events resulting in death) Last	liate	Due to (or as a	consequ	ence of):		7105	(710)						
Division of Vital Records, P.O. Box 68760	In othe Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	hs?	ic. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic Other (s		у			2	23d. Date Mon	e of delive	ery Day Year
ls, P.O	requires that the de been signed by the should be detached	ed by PI	Part II. Other significant	t conditions con	_	it not resu	ulting in the u	nderlying	cause giv	en in Part I.	_ 2					e cause of death?
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tal F	Physician; The law this certificate has al director, page 2 a		25. Was case referred to examiner?	medical						ace of Death (C		1 Yes one)	2 ≥ No	11	☐ Yes	2 L No
<u> </u>	Physic r this c eral dire	욘	1 Yes 2 No 27. Manner of Death) HO	28a. Date of injur	/	ER/Outpatien 28b. Time of		Othe 28c. Injury	4 Nursin		5 Resid				
ion	tending leath. or: Afte the fund	Certificate:	2 Accident	Pending Investigation Could not be	(Month, Day,		injury	М	work?		- 1	3000 IDG II				
Divis	the Hospital or Attending In the Hospital or Attending In the Funeral Director: After mpleted filled in by the funer		4 Homicide	determined	28e. Place of Injui building, etc.	(Specify)					C	City or Tow	n, State)			Route Number,
;	he Hosp in 24 ho he Fune pleted f	Medical	(Check 2 L N	Medical Examine	ian: To the best of r r: On the basis of ex Practioner: To the b	amination	and/or invest	igation, in	my opinior	n, death occurr	ed at the tir	me, date a	nd place,	and due	to the cau	se(s) and manner stated.
	Vith To th		29b. Signature and title o	of certifier		-		29	c. License	number			29d. Date	e signed	(Month, L	
7	10		30. Name and address o	f person who cor					<u>ر</u> ر	-13/			MU	NH	, 25,	2>) >
	Ų Stat	e l	Denul 31. Date filed (Month, Da		32. Registral	3 U	ess y	vil	kens	· Au	0	Balt	Imp	<u> </u>	10	R1227
	Registra	~	AUG 092		result of	. 7										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Seasons Hospice Randallsto<u>wn</u> <u>Baltimore</u> Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthp... Country) MD **Funeral** Days Hours Sept 22 1 □ M 2x□ F 474-48-7425 64 **Director** 1945 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" perfections on the trainment. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 🕅 No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4805 Deer Park Road 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes X☐ No If Yes, Give Yes, 1 Yes 2 No Specify. 3
Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland Edward Redman Marcellena May Boston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James P. Goff (Spouse) 4805 Deer Park Rd., Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem Park 8/9/2010 Sykesville, MD ^{22. N}HATGAT PONERAL HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee HCU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed in 24 hours after death. certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1/2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4

Nursing Home After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation neral □irector: / I filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a
To the Funeral of Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature

31. Date filed (Month, Day,

AUG 0 9 2010

⊘haturè

address of person who completed cause of death (Item 23a) (Type

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of N	Maryland		artment tificate				F	Reg. No.	2010	24	769
44	Physic /Medi		Decedent's Name (First, Mid-Baby Girl Gai Baby Girl Gai Aa. Facility Name (If not institution)	nes		- <u>-</u>	L., 6; -			Ju	Date of Dea Month	Day	201	0 162	of Death
ام	Exami	ner	The Johns Hopkir	, 0	r) -		Baltin	,	Location of	Death		4c.	County of Dea	th	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	ast birthday)	If Under	1 Year	If Under 2	4 Hrs. 8. I	Date of Birth	1	9. Bir	thplace (State	or Foreign
ш	Director		INFANT	1 □ M 2 🖺 F		Yrs.	Months	Days	Hours 4	3 [№]] ј	Date of Birth Month, Day 11y 31	, rear)		ryland	
	and		Usual Residence of Decedent 10a. State 10b. Coun	v	10c. City	. Town or Lo	cation							10d. Inside	City Limits
	Maryli F sho	to	MD	,	Ва	ltimo:	ce								es 2 🗆 No
	th the or 282 notif	Director	10e. Street and Number				10f. Zip-	Code			1	l 0g. Citi:	zen of What Co	ountry?	
	ath wii	ral	4600 Valley					206				US	SA		
	items	Funeral	11. Marital Status 1 X Never Married 2 ☐ Ma	12. Was Deceder Armed Force rried 1 7 Yes 2	3?	3. 13.	Was Deced f Yes, speci	ent of Hi ify Cuba	spanic Origi n, Mexican, I	in? (Specify Puerto Rica	Yes or No- n, etc.)		14. Race - Ame Black, Whit	e. etc.	
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show lical Examiner must be notified at	by	3 Widowed 4 Divorce	If Ves Give			1 ☐ Yes 2	⊠ No	Specify:				Specify: b1a	ack	
5-0	"natural", edical Exa	Completed		ent's Education est grade completed)		(Give	dent's Usua kind of won	k done d	turina most d	of working		16b. Ki	nd of Business	/Industry	
2121	within the. than " e Mec	ldu	Elementary/Secondary (0-12 INFANT		r 5+)	life. I	DO NOT use IFANT	e retired)					INFANT		
d 2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle			11	ITANI	T	18. Mother	's Name (Fi	rst, Middle,				
lan	ald be fental rked c	To Be						ŀ	Dak	eana	Gaine	S			
, Maryland	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		19a. Informant's Name/Relation Dakeana Gaine	1 () /									ore, MI		5
Baltimore,	Pages 1 and the rest of the sunt: If item		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 XOther		e ce	lace of Dispo emetery, cren	sition (Nam natory or oth	e of her place	e)	Date		20c. Lo	cation - City or	Town, State	
Balti	permit. Departr Importa any inju		21. Signature of Euneral Service ROTIALO	S. Wade, Di	rector	22			s of Facility			-	Board timore	, MD 21	1201
و	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, a shock, or heart failure. Lis immedia. Cause (Final disease or dition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Duè to (or a	ed the death. line. Is a consequence a conse	tions ence of):						rest,		Approxim Interval B Onset and	etween
3760,	cate be executed oblysician and the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	s a consequ	ence of):									
P.O. Box 68	The law requires that the death certificat the has been signed by the attending phypage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3	Ectopic pro Other (spe					2	3d. Date of de Month	livery Day	Year
ຜົ	w requires that the been signed by should be detact	by	Part II. Other significant condit	ions contributing to death	but not resu	ulting in the u	nderlying c	ause giv	en in Part I.		23e. Did tol		se contribute t		
Il Record		Completed				-					24a. Was ar autops perforn 1 Yes	y	24b. Were au prior to death?	topsy finding completion o	s available f cause of
Vital	stcian: Th certificate irector, pa	m	25. Was case referred to medical examiner? 1 √ Yes 2 □ No	Hospital:				Othe	r	f Death (Che	-				
of	ding Phys I. After this of funeral di	٦: ٢	27. Manner of Death	28a. Date of In	jury	R/Outpatient 28b. Time of		c. Injury	4 🗆 Nursi		5 Reside		Other (Spector)	cify)	
ion	ath. : After ie fune	atio	1 ✓ Natural 5 ☐ Pend 2 ☐ Accident inves	ng (Month, D igation	ay Year)	Injury	М	Work′ 1 □ Y	? 'es 2 □ No						
Division	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director.	Certification:	3 Suicide 6 Could determ	ninod 200. I lace of I	njury - At hon etc. (Specify)	ne, farm, stre	et, factory,	office			ocation (Si Dify or Town		d Number or R	ural Route Nu	ımber,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the function of		29a. Certifier 1 Certify (check only one)	ng Physician: To the best I Examiner: On the basis and manner	of examination	ledge, death on and/or inv	occurred a restigation,	t the tim in my op	e, date and pinion, death	place, and o	due to the c	ause(s)	and manner as place, and du	s stated. e to the cause	e(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifi	er			29c.	License			2	9d. Date	signed (Monta	h, Day, Year)	
		-	10116	1				<u> </u>	ES-	000		JUI	4 31,	2010	
			30. Name and address of perso	who completed cause of	death (Item	23a) (Type,	Print)		6	OO Nor	th Wal	fe St	, Baltimo	ore MD	21227
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatu	re Jan	Les I		0	30 1401	1701		., - amm	, IVID,	1 1 1 2 0 1
	Registr	ar	AUG 0.92	010 Serger	J Ja.	17									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 24a,25 per dr., g906,08/09/2010dnb
Certificate of Death

Reg. Ng For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12^{Day} July 2ÖÏO 11:51P M Elmer Harris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Montgomery Washington Adventist If Under 1 Year If Under 24 Hrs. 5. Social Security Numberunk | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) UNK **Funeral** April 19, 1947 Months Days Hours Min. 63 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location unk 10b. County unk 10d. Inside City Limits 10a State with the Maryland Director ian "natural", or items 23a or 28a-f s Medical Examiner must be notified unk $_{\mid \; \square \; {\sf Yes} \; \; 2 \; \square \; {\sf No}}$ MD 10f. Zip Code unk 10e, Street and Number 11nk 10g. Citizen of What Country? Funeral USA permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? UNK 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates 3 Uvidowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than College (1-4 or 5+) unk Elementary/Seconday (0-12) traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Carroll Avenue; Takoma Park, Maryland 20912 Washington Adventist Hospital other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) In State icen Wad 225 Magreed Altres to Fragity Board; 655 W. Baltimore Street Director Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 2 No Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 🗶 No Other: ၉ 1 🔲 Yes 2 ER/Outpatient 3 DOA Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Natural 5 Pending work? 1 Pes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

Registrar

29b. Signature and title of certifier

092010

30 Name and addre

31. Date Hed (M

leted cause of death (Item 23a (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 17 per fb 9906 8-9-10 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical Town, or Location of Death acility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** M 2 F Yrs. 20 0602 84 8 DEC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Connells villE Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15425 90 USA MORRELL 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes, 2 In No If Yes, Give Year or Dates: 1946 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 20 No Baltimore, Maryland 21215-0036 Specify: Completed by 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CLOSURER DIVISION Elementary/Secondary (0-12) College (1-4or 5+) ANCHOR HOCKING CORP. ENGINEER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BALSLEY 2 HEFFLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 MORRELL AVE CONNELLSVILLE HEFFLE VanE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 8/7/2010 GREEN RIDGEMEN. PARK CONNELLSVILLE, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility | V 2 UM SWV

23a. Fartt. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility, N 2 UM BWN SH & MON. Go SYKESVILLE RD ELDERSBURG-MD 21784 Approximate Interval Between Onset and Death Immediate Cause (Final ears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year in the past 12 months? Day 1 ☐ Yes 2 ☐ No 9 Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions 2 100 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 ☐ Yes 2 00 4 Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To nours after death.

neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 41 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syhesville mD 21784 710 Obrecht Rd. CRNP Bonnies. Dank 31. Date filed (Month, Day, Year) adistrar's Signature State Registrar AUG 0 9 2010

DHMH 17 Rev 1/2001

10-05296 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Bruce Harmesan 2010 24772 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 15, 2010 0832 hrs Medical Examiner Bruce Harmesan 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Baltimore Mercy Hospital 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State orunk **Funeral** Days Director July 14, 1952 58 1X M 2 F Country) Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State unk unk unk Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important; If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Direct 10e. Street and Number 10f. Zip Code unk 10g, Citizen of What Country? unk USA Funeral 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? **unk** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 Yes 4 Divorced f Yes, Give Year Yes 2X No specify: Specify white 3 Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work donatink 16b. Kind of Business/Industry unk during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Police Department 601 E. Fayette Street; Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 K Other Specify: in state 21. Signature of Funeral Since Licensee Rona 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 Approximate Interval Physician t I. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and List only one cause on each line /Medical Death a. Complications of Chronic Alcoholism Immediate Chuse (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical AMENDED signed by the attending physician I be detached for use as the burial UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, this certificate has been if director, page 2 should 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? 1 ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) funeral director, 25. Was case referred to medical æ Other₄ examiner? 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Inpatient ဥ 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide

Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. To the Bospital or Attendi within 24 hours after death. To the Funeral Director: filled in by the

O.C.M.E

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day, Year) AUG 0 9 2010

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

Medical

State

Registrar

29d. Date signed (Month, Day, Year)

July 16, 2010

10-05749 John Henry, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 24773 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 31, 2010 Modical Examiner 1348 hrs JOHN HENRY, JR. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Days Director Country) MD 1XX M 2 F Yrs NOV 12, 1967 218.04.8097 42 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 YY No 28a-f show **ADAMS** LITTLESTOWN hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 14 BOYER ST. 17340 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 XX Never Married 2 Married Yes 2 XX No 3 Widowed 4 Divorced If Yes, Give Year Yes 2 XX No specify: Specify: è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou.
Department of Health and Mental Hygiene.
Important: If iten 27 is marked other than "nati during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **AUTOMOBILE** AUTO TECHNICIAN 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN FRANKLIN HENRY, SR. unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT LEE HENRY JR. 235 HAMMARLEE RD. GLEN BURNIE, MD 21060 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery. crematory or other place) 1 Burial 2 XXCremation 3 Removal from State BALTIMORE, MD BAYVIEW/CREMATORY INC 8.5.2010 nation 5 Other Sp nature of Funeral Service 22. Name and Address of Facility
FINK FUNERAL HOME. P.A. 426 CRAIN HWY SW GLEN BURNIE, MD 21061 GREGORY FINE complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval art I. Enter the disease o Physician een Onset and /Medical Death Cerebral Infarction Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - tran ician/Medical AMENDED 23a,b,pt.II,27 per me g907 9-10-10 vt X UNPENDED The law requires that the death certificate be of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Physi 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Cirrhosis 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes this certificate ✓ Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No After t 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 1 Yes 2 No Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be To the Hosp.
within 24 hours afte determined Homicide 29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b O.C.M.E. August 4, 2010 nd address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ avearo 16:55 PM John Wimhor 02 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harber Hospital Baltimore Social Security Number 6. Sex 1 ▲ M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month Day, Year) Months Days Hours Director 213-32-0110 76 Maryland May Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Tes 2 No Linthicum Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 622 Franklin Avenue 21090 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) D.C.A. Company 12 0 Sheetmetal Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Schumacher William Н. Imhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 622 Franklin Avenue, Linthicum, Maryland 21090 Carol L. Imhoff Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park Aug. 11, 2010 Elkridge, Maryland 21. Signature of Fur eral Service Livers 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. nue, Baltimore, Maryland 21225 237 East Patapsco Avenue, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between In mediate Cause (Final Onset and Death Physician OPD exacerbation isease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transif Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Year 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Prostate cancer, Hypertension, Africal Pibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv death? deatn? 1 🗌 Yes 2 🗙 No ☐ Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29c. License number Resident MD RESØØ1

State Registrar Hadas

31. Date filed (Month, Day, Year)

AUG 092010

Hosp Hul

3001 S. Hanover St.

Hurbor

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

SKURSKU

10-05851 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Anthony Jones State of Maryland / Department of Health and Mental Hygiene 2010 24775 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Examiner JONES MICHAEL ANTHONY 0355 hrs August 5, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 7901 Mayford Avenue Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Mary land Country) Months Days Hours Director 220-06-1217 26 July 6, 1984 1 X M 2 F Usual Residence of Decedent ıny 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 Yes 2 X No 28a-f shov Baltimore, MD 21215-UU30
permit. Pages I and 2 should be filed within 72 hours after death with the Manyland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 7901 Mayford Avenue 21122 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 Married White, etc. Yes 2 X No Specify: White 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled None 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jones Barclay Susan J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan J. Jones (Mother) 7901 Mayford Avenue, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory of other place)
Cedar Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State August 11,201**0** Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service License McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval ailure. List only one cause on each line Between Onset and /Medical Death a. Hanging mmediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): <u>ne</u> cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed the attending physician and ed for use as the burial - trans Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? signed 2 Drug and Alcohol Use 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed' death? Yes 2 V No 2 No Yes Hospital or Attending Physician; 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🖊 Other Scene ER/Outpatient 3 DOA 1 Yes No 28a. Date of Injury (Month, Day Year) Aug 5, 2010 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject hung self Natural 0000 hrs within 24 hours after death.

To the Funeral Director:
completely filled in by the fi Director: d in by the f 1 Yes 2 ✔ No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 7901 Mayford Avenue, Pasadena, MD determined (Specify) Single Family Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E August 5, 2010 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examine 111 Penn Street, Baltimore, MD 21201 32. Registrates Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July 9:01 Physician/ olores Kne 20117 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARbon Hospital 13Altimoize 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Months Days Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10b. County **Funeral Director** MD N/A Baltimore Yes 2 No 10e. Street and Number 1814 Belt Street 10f. Zip Code 10g. Citizen of What Country? 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 11. Marital Status Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married white 1 Yes XX No Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Sales Factory Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Benjamin Williams Margaret Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Teaberry Avenue, Edgewood MD 21040 19a. Informant's Name/Relationship (Type, Print)
Barbara A. Tutin / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville VA Cemetery 8/3/2010 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Crownsville MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final CARDIAC DYSPHYTHMIA mediate Physician/ disease or condition Medical resulting in death) Examiner ischemic CARDIUMTOPATHY PARC Sequentially list conditions, Be Completed by Physician/Medical Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events ANTENA DISEASE or Attending Physician: The law requires that the death certificate be executed CORONAN attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23h. Was decedent pregnant in the past 12 months? Month Year Day Yes 2-No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULMUMPER DISEASE MONIC OBSTIZUCTIVE 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSIUM autopsy performed?
☐ Yes 2 ☐ No Diabeter mellitus 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1- Yes 2 No 26. Place of Death (Check only one) Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: s after death. Il Director: After t injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital or within 24 hours a' To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioners of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

State Registrar 3091, South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12D

32 Registra Signatural

I. BUKBOVITZ

D0061438

Hanover St Baltimore MD 21235

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O th 327 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Date of bill. (Month, Day, Year) 5. 1934 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗘 Months Days Hours Mir Yrs **Director** 241.46.0074 Nov 5, Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Severn 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 7733 Telegraph Rd 21144 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1XX Never Married 2 Married þ 1 ☐ Yes 2√. If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 2×× No 1 ☐ Yes 2 x XNo Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Preston Weatherman Wilma Shoemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Welborn 174 Virginia Lane, Apt L , Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crownsville Veterans Cem | Aug 5, 2010 Crownsville, MD ute of Funeral Service Lice 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Gregory Fink Glen Burnie, M01148 Md 21061 23a. Part 1 Enter the disease, or om vications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure) List of ly or exclusion and line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or conditi av resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Pospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property of the physician and property. After this certificate has been signed by the attending physician and Cause (Disease or linjury the burial-tran Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Xivo 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy page 2 should be detached for Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2 **2** No Other: 1 Tes 4 Nursing Home 5 Residence 6 Stother (Specify) TATE HOUSE 1 \square Inpatient 2 \square ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Pwithin 2. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, EGG State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Physician/ ZONO 1540 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Recional 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 373-42-5469 1**XX**M 2 □ F Months Days Hours 67 MI Director Usual Residence of Decedent or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MI Macomb Macomb Township 1 Yes 2 No 10e. Street and Number 17245 Averhill Blvd 10g. Citizen of What Country? 10f. Zip Code 48042 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Air 1 Yes 2 No Force Black, White, etc. 1 Never Married Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZONo Specify: If Yes, Give Year or Dates white Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pipe Fitter Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Aloysious L. Lack Marie Nabozny 19a Informant's Name/Relationship (Type, Print)
Josephine Lack /Wife 19b. Maijing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 17245 Averhill Blvd., Macomb Township MI 48042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Resurrection Cemetery 1 Burial 2 Cremation 3 Removal from State 7/20/10 Clinton Township, ΜI 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Victor Doda 23 Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 21230 £ € 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MINS WEBRETTON Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Id be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 N Director: After this certificate has 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗆 No 1 X Yes ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical _Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address K TTH 17 32. Registrar's Signat

DHMH 17 Rev 7/2009

State

Registrar

AUG 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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72 hours		15. Decedent's Edu	cation	16a.		nt's Usual			-1 (6)		16b. H	Kind of Bus	iness/In	dustry	
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nd 2121 e filed within al Hygiene. lother than vent, the Ma	Cou	12	0		resi	ident		couns						1timore	
Maryland 21215-0036 d 2 should be filed within 72 hours af tht and Mental Hygiene. Ith and Mental Hygiene. Z7 is marked other than "natural", or traumatic event, the Medical Event	To Be	17. Father's Name (First, Middle, Last) Edward Lee							's Name (F thy I			thy		ley	
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To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physical Examination	ician: To the best ier: On the basi and manner	est of my knowledge, is of examination and r stated.	death o	occurred at stigation, in	the time	, date and nion, death	place, and occurred	due to the	e cause(s , date an) and man d place, ar	ner as s	ated. the cause(s)	
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		Muhal	, wr			D	006	77	35		Ju	14,	14,	2010	
		30. Name and address of person who co		of death (Item 23a)	Type, Pr	rint) Rave	en f	Blvd	Bo	uth		0 /		21239	
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State of Maryland / Department of Health and Mental Hygiene

		-	For State Of IVI	aryland / Depa	artment of F tificate of L		entai Hygie Reg	211111	24781
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Siu W	ah Lee			2. Date of Death Month	g 5, 2010 ^{Year}	3. Time of Death 4:40 PM
	Examin		4a. Facility Name (if not institution, give street and number) 8755 Ruppert Ct.		4b. City, Town, or	Location of Death Ellicott City		4c. County of Death	oward
Ī	Funeral Director		5. Social Security Number 117-74-2259 6. Sex. 1 M 2 \square F 7. Agr	e (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Nov 17	9. Birth Cour	place (State or Foreign ntry) China
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State	10c. City, Town or Loc	cation	Ellicott City			10d. Inside City Limits
	with the M 23a or 28 ust be noti	eral Dir	10e. Street and Number 8755 Ruppert Ct.		10f. Zip Code	21043	10g	. Citizen of What Cou	
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes, Give Year or Dates.	No 1	Yes, specify Cuba		fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	ithin 72 ho ene. r than "nai the Medic	Comple	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give I	O NOT use retired)	ation Juring most of working Server	7 16	b. Kind of Business Ir	Service
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Maryland	d 2 should alth and M 1 27 is ma er traumai		19a. Informant's Name/Relationship (Type, Print) Vivian Lee Daughter			and Number or Rural I t. Ellicott City		y or Town, State, Zip	Code)
Baltimore,	Page 1 an nent of He ant: If iterr ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Atlantic	sition (Name of natory or other plac Crematory , L	e) LC Aug	ote 20 08, 2010	c. Location - City or T Glen B u	own, State urnie, MD
Balti	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	01793	. Name and Addres Slack F 3871 OI	uneral Home, P d Columbia Pik	.A. e Ellicott City	y, MD 21043	
	Physician/		23a. Part Inter the rease, or complication to t caused shock, or heart Hilure. List only one cause on each line immediate Cause (Final disease or condition	I the death. Do not ente e. MIC CaV	A	4	respiratory arrest,		Approximate Interval Between Onset and Death
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092	ate be exe ohysician a the burlal-	edical E	resulting in death) Last Due to (or as a	a consequence oi).					
Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 _	Ectopic pregnand Other (specify)	у		23d. Date of deliver Month	rery Day Year
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Division of Vital Records,	The law require sate has been si page 2 should b	Completed					24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
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n			30. Name and address of person who completed cause of d EMILY S. Fall Child	eath (Item 23a) (Type, F			Baltini	ore, MI) 21201
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 Day 2010 Year Physician/ Elizabeth V. Locklear 1:30 August Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 12 Holly Springs Court Nottingham Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace /State or Foreign **Funeral** 1 M 2 XF Months Days Hours 0472971931 Director 79 213-30-8242 Georgia Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Holly Springs Court 21236 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Ves Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gordon Lee Arnold Anna Mae Gault and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Sheila Everett - Daughter 12 Holly Springs Court Nottingham, Maryland 21236 permit. Page 1 and : Department of Healt. Important: If item 2: any injury or other th Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) cemetery, crematory or other place) Oak Lawn Cemetery 08/07/2010 Baltimore, Maryland 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Signature of Funeral Service License 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Adenocarcinoma Metastatic disease or condition INKNOWN Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
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1 \(\subseteq \text{Yes} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2' No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending Natural 1 Yes 2 🗌 No hours after death. Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Howithin 24 h Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063176 August 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Mienyenwa 31. Date filed (Month, Day, Year)

AUG 0 9 2010

Box 68760

P.O.

Records,

Division of Vital

MD

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32. Registrar's Signature

8868 Belair Road Baltimore

Registrar

AUG 0 9 2010

2010

AUGUST 1

BOY

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		For State Registrar	State of Ma	arylanu /	•	tificate of		iliu ivie		Reg. No	0010	21	701
		Hegistrar Name (First, Middle)	le, Last)		00/1		D 04111	2	. Date of Dea		2010	3. Tim	e of Death
Physici		John J. Lol						J	Month uly 26	, Da 2	.010 Year	4:10	M MA C
/Medic	_	4a. Facility Name (If not institutio				4b. City, Town, c	or Location of			_	. County of Deat	1	
LAAIIIII	61	7317 Eden I	Brook Drive			Colu	mbia				Howard	i	
Funeral Director		5. Social Security Number 219–18–6393	6. Sex 1⊠ M 2□ F	e (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8	Date of Birtl (Month, Day Dec 12	h , Year) , 19	9. Birt Co Mar	nplace (Sta untry) yland	ite or Foreign
pu 🛦		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Tow	vn or Loc	ation						10d. Insid	e City Limits
sho	5		vard	Colum		ation							∕es 2 X No
the N	Director	10e. Street and Number	valu	OO Z GII		10f. Zip Code				10a. Ci	tizen of What Co	untry?	
filed within 72 hours after death with the Maryland Hygiene. The Than "natural", or items 23a or 28a-f show ent, the Medical Examination aust banalified at		7317 Eden Bro	ook Drive			21046				-	ISA	ľ	
ns 2	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. W	/as Decedent of I	Hispanic Orig	in? (Speci	fy Yes or No-		14. Race - Ame		٦,
or iter		1 ☐ Never Married 2 🛣 Mar		ı₀ 1943 –	l If	Yes, specify Cub	an, Mexican,	Puerto Ri	can, etc.)		Black, White		
urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1946	1	□Yes 21 No	Specify:				Specify: bla	CK	
72 ho	etec	15. Deceder	nt's Education est grade completed)	168	a. Decede	ent's Usual Occup	pation during most	of working	Ţ	16b. K	(ind of Business/	ndustry	
ithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. D	O NOT use retire	d)				religion		
lled w lygie ther t	ပိ	17. Father's Name (First, Middle,	unk unk		ерт	scopal p		r's Name /	First, Middle,			-	
d be f ental l ed of	Be	James Vincent							Mae V				
should Me Me mark	유	19a. Informant's Name/Relations		19	b. Mailing	Address (Street	L and Number	r or Rural i	Route Numbe	er, City	or Town, State, 2	(ip Code)	
nd 2 sulth all		Carol Lobell			731	7 Eden B	rook I	rive	; Colu	mbia	a, Maryl	and 2	1046
s 1 ag of Hea item othe		20a. Method of Disposition		20b. Place o	of Dispos	ition (Name of atory or other pla	ce)	Dat	e	20c. L	ocation - City or	Town, State	9
Page nent c nt: If		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (5		Cometa	ory, oronn	atory or other pla							
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination rust be neithed at once.		21. Signature of Superal Service	Sicensae Dir	ectar	22.	Name and Addre	ess of Facility	Stat	e Anat	omy	Board		
9 9 E 8 9		Inn	1/1000			655 W. B	altimo	ore S	treet;	Bal	ltimore,	MD 2	1201
Physician /Medical		23a. Part 1. The the disease, shock, or art failure. List immediate Cause (Final disease or condition resulting in death)	t only one cause on each lin	the death. Do	show	1	ing, such as o	1	respiratory ar		-	Approxi Interval Onset a	mate Between and Death
Examiner	_	Sequentially list conditions	b	-	- 10								
ted 1sit	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	9 01):								
executed and al-transit	xar	that initiated events resulting in death) Last	c Due to (or as	a consequence	e of):								
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tificat ig phy as the	edi		- u.					75.00			3025		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		Ectopic pregnant Other (specify)	су				23d. Date of de Month	ivery Day	Year
e law requires that the de has been signed by the le 2 should be detached		Part II. Other significant conditi	ons contributing to death bu	ut not resulting	in the un	derlying cause giv	ven in Part I.		23e. Did to	obacco	use contribute to	the cause	of death?
Jires sign d be	d by		•						1 🗆 \	es 2	No 3□ P	obably 4	Unknown
v requ	Completed								24a. Was	an	24b. Were at	itonsv findi	ngs available
he lav e has	dmo								autop	sy rmed?	prior to death?	completion	of cause of
an: T tificat or, pa		25. Was case referred to medica	1				26 Place	of Death /	1 □Yes Check only o	2 []	o 1 ∐Yes	2 □ No	
/sicie	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 EB/O	Outnatient	3 □ DOA Oti	har:		1/		6 ☐ Other (Spe	cify)	
g Phy ier thi	Ë	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of Injury	28c. Inju			d. Describe h			0.177	
ath. rr: Aft	atio		gation	y, rear)	ilijui y		Yes 2□N	No					
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		ry - At home, f c. (Specify)	arm, stre	et, factory, office		28	f. Location (5 City or Tow	Street a vn, Stat	nd Number or Ri e)	ıral Route	Number,
ne Hospi n 24 hour ne Funer sletely fill	Medical		ng Physician: To the best of Examiner: On the basis of and manner sta	f examination a									ise(s)
To the Complete Compl	ž	29b. Signature and title of certifie	T na	7		29c. Licen	se number			29d. Da	ate signed (Mont	h, Day, Yea	ar)
			Ella Ille	20 MIC)	103	5005	21		AL	gust	J.	2010
•		30. Name and address of person	who completed cause of de	eath (Item 23a)	(Type, P	Brain R	D L	7/k.	dse -	LAIT	~ 10) _X_	
		CHAN WITH	SMD 818	6 Lean	M. A	oraun K	a [STILL	uff >	MIL) 216	0	

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death SName (First, Middle, Last) 2. Date of Death Physician/ 0042 Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OLUMBIA 8. Date of Birth (Month, Day, Year) Jul 1, 1929 Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours Country) 367-24-5775 81 Michiga Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Howard Columbia 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Freetown Rd. #214 21044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Secretary Physician's Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Peter Yacos Tomsha Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Michalski spouse 6500 Freetown Rd. #214 Columbia, MD 21044 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Aug 08, 2010 Glen Burnie, MD **Atlantic Crematory** 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Fundral Service Licens 23a. Part 1. Enter the resease, or complicate no hat caused shock, or heart ailure. List only one cause on each line. sease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final OSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Physician/Medical Examine within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 E No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2010 6

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

AUG 09

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 80 00 1E 1215 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 31 Carroll Road Pasadena Anne Arundel 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗶 F Hours Director 219-26-8896 71 1939 January 4, Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ıral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Cedar Drive 21061 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 💢 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meaone. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Laborer Locke Insulator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Darr Patterson Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette M. Duvall (Daughter) 31 Carroll Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 📈 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem. Park Elkridge, Maryland Aug. 11,2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 Fast Fort Avenue, Baltimore, Maryland 21230 21. Signature of Funeral Service License and P = 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death I mediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi ause (Disease or injury attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 W No Month Day Year Pregnant at time of death the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy perform death?
1 Yes 2 No Director: After this certificate Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗌 Residence 6 🔊 Other (Specify) 2 **N**o DAUGHTER'S မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Wertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

RIEGE

32. Registrar's Signature

10-05620 Mariah Leigh Mo		Š	rpe or Print in State of Maryla	and / Depa	rtment of	Health	and N				10 2478
		1- For State Registrar 1. Decedent's Name (First, Mid	Idlo t oat)	Cen	tificate of	Death			Re 2. Date of Dear	sg. 140.	
Physicia Medical Exami									Month July 27, 20	Day Year	3. Time of Death 1138 hrs
		Mariah Leigh 4a. Facility Name (if not institut		umber)	1	4b. City, Tov	wn, or Loc	ation of Death		4c. County of D	Death
1 · ·		420 Pamela Road #	С			Glen B	urnie			Anne Arun	del
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under		f Under 24Hrs Hours Min	_		Birthplace (State or oreign
Director		unk	1 M 2 X F		1 Yrs		Days	riouis Iviii	July 2	21, 2009	CountryFlorida
any		Usual Residence of Decedent 10a. State 10b. Count	<i>'</i>	10c City	Town or Locati	on					10d. Inside City Limits
d how a	L		Arundel	Linth							1 Yes 2 No
arylan 8a-f si	Director	10e. Street and Number	ZII GIIG C I	122201	1200	10f. Zip Co	ode		1	ng. Citizen of What	Country?
the M. n or 2: tified	Dire	462 Susan Ct.				2109	0		11	nited Sta	ites
with ms 23	eral	11. Marital Status		cedent Ever in U.S		s Decedent	of Hispan	ic Origin? (Sr	ecify Yes or No	14. Race - A	merican Indian, Black,
death or ite	Funeral		Married Armed F	2 X No				exican, Puerto	Rican, etc.)	White, e	White
s after ral", niner	by		ivorced If Yes, Give Yes or Dates:		16a. Deceden	Yes 2X				Specify:	
2 hour "natu	Completed	 Decedent's Education (Sp Elementary/Secondary (0-12 						NOT use reti		16b. Kind of Busin	ess/industry
336 thin 7: than than	nple	N/A	N/A		A/A					N/A	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middl	e, Last)				18.N	Nother's Name	(First, Middle, N	Maiden Surname)	
121 1 be fil ental I erked vent,	Be	Scott Christop							larie G		
D 2: should and M 7 is m	٩	19a. Informant's Name/Relation			1					ber, City or Town, S	_
mnd 2 sho ealth and tem 27 is traumati	-	Nicole Marie 20a. Method of Disposition	Gorman/Mo		462 Su lace of Disposi				ım, Mary Date	1and 2109 20c. Location - Cit	
Ges 1. trof H		1 Burial 2 XCrematic	on 3 Removal fr	C Cr	ematory or oth	er place)		· 1	1,2010		nie, Maryland
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other 5				ame and Ad			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,
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Physician		23a. Part I. Enter the disease, of failure. List only one caus		aused the death. I							Approximate Interval Between Onset and
/ /Medical Examiner		Immediate Cause (Final diseas	e a Cardi	ac arrhy							Death
up -		or condition resulting in death)	Due to (or as a	consequence of)	:						
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Box 68760, e death certificate b the attending physical ed for use as the bu	Physician/M	23b. Was decedent pregnant in past 12 months?	I Live D	oirth nant at time of dea	~	al death	3E	ctopic pregna	ncy	Month	Day Year
Sox leath c e atten for us	/sic	1 Yes 2 V No 9 U	nknown 9 Unkno		" 5 Oth	ner (Specify	<i>'</i>)				
O. Enat the code by the etached		Part II. Other significant cond	itions contributing to	o death but not res	sulting in the u	nderlying ca	ause given	in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
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eco he law nte has	Ĕ			•					perfor	med? deat	
al R an: T ertifice tor, pe	BeC	25. Was case referred to medic	al			26.	Place of D	Death (Check o			
of Vital Records, in Physician: The law requirement the this certificate has been simeral director, page 2 should the	ol	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 E	R/Outpatient	3 DOA	Othe	er4 Nursin	g Home 5 🔲 I	Residence 6 🗸 0	ther: Scene
n of ling Pl After funera	Ë	27. Manner of Death 1 X Natural 5 Per		of Injury 2 , Day,Year)	28b. Time of In		. Injury at		28d. Describe h	ow injury occurred	
Division tal or Attendir rs after death.	ertification:		nding estigation				Yes				
Divis	E E	det	uld not be 28e. Place ermined (Specify)	e of Injury - At hon	ne, farm, stree	t, factory, of	ffice buildi	ng, etc.	28f. Location (S or Town, St		r Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal—transit	O	4 Homicide 29a. Certifier 1 Continues	Physician: To the bes	at of my knowledge	death coors	ed at the time	me data a	nd place, and	due to the cause	e(s) and manner co	stated
thin 24 the F	ledical	[or our only	aminer: On the basis	of examination and							
F. 2 5 0	Me	29b. Signature and title of certif				29c. L	icense nui	mber		29d. Date signed	(Month, Day, Year)
		hig n	S. No	C		C	D.C.M.E	Ξ.		July 28, 2010	
	ľ	30. Name and address of perso	n who completed caus	se of death (Item 2	?3a)					-	

State Registrar

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Maryland		artment of H		and M	1ental Hyg	giene	1.0	21.700
_			Registrar	(4)		Cer	tificate of E	eath			Reg. No. U	10	24788
	Physicia	n/	1. Decedent's Name (First, Middle		- 0 +1					2. Date of Dea Month	Day	Year	3. Time of Death
	Medic		Walter 4a. Facility Name (if not institution		cCarthy		4b. City, Town, or	I continu	of Dooth	August_		010] 3:30 a ^M
	Examin	er			4)		_		n Death		4c. County		
	Funeral	-	Gilchrist Ho 5. Social Security Number		Age (In yrs. last	birthday)	If Under 1 Year	son If Under 2		8. Date of Birt	h	9. Births	place (State or Foreign
	Director		220-14-0497	1 🕅 M 2 □ F	86	Yrs.	Months Days	Hours	Min.	(Month, Day August	31, 1923	Coun Ma	ryland
	, wo	,	Usual Residence of Decedent 10a. State 10b. County		10 00 7	-							
	ryland -f sh	cto			10c. City, 7							1	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Ma r 28a notif	Dire	MD Ba1 10e. Street and Number	timore		Owing	gs Mills 10f. Zip Code						
	ith th	Funeral Director	3414 Associat	od Way Rla	da 3 Ant	- 102	21117				10g. Citizen of	5.A.	ntry ?
	ath w	nue	11. Marital Status	12. Was Decede			Was Decedent of Hi	spanic Orio	in? (Spe	cifv Yes or No-		ce - Americ	ean Indian
9	or it		1 Never Married 2 🙀 Mar				f Yes, specify Cubar	n, Mexican,	, Puerto	Rican, etc.)		ck, White,	
903	ırs afi ural", I Exa	ed	3 - Widowed 4 - Divorced	If Yes, Give Year or Date:	s. WWII		I∐ Yes 2 🔀 No	Specify:			Specify	" W.	hite
21215-0036	2 hou "nat	Completed by		nt's Education est grade completed)		(Give I	dent's Usual Occupa kind of work done d	ation luring most	of worki	ng	16b. Kind of B	iusiness Inc	dustry
121	thin 7	ω	Elementary/Seconday (0-12)	College (1-4	or 5+)		O NOT use retired)	Manag			7	Uр	
d 2	a filed within 7 tal Hygiene. ed other than event, the M	Be (17. Father's Name (First, Middle,	Last)			District			e (First, Middle, i			
Maryland	be fill ental ked c	은	Chadwick	•	Carthy			TO. INIOTHO		211a	Mille	•	
ary	nd Mind Mind Mind Mind Mind Mind		19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a	and Numbe					Code) 21117
Ž	d 2 st alth a 27 is		Jennie V. McCa	rthy Wife	1							. ,	Mills, MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other place	T		Date	20c. Location		
<u>=</u>	Page nent ant: It		1 🙀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	3 ☐ Removal from St Specify)	aic		Cemetery		8-1	0-2010	Woodla	wn, M	laryland
Salt	permit. Departi Import any inj once.		21. Signature of Funeral Service	Licensee	a.k.	22	. Name and Addres	s of Facility	у 1	1824 Re	isterst	own ?	Road
<u>—</u>	9 Q E # 9		Sephe	n711-	nain		LINE FUNE					MD :	21136
			23a. Part 1. Enter the disease, of shock, or heart failure. List	r complications that cau only one cause on each	sed the death, (line.	Do not ente	er the mode of dying	g, such as o	cardiac o	r respiratory arr	est,		Approximate Interval Between
	hysician/		Immediate Cause (Final disease or condition	_aD1	emer	utis	0					200	Onset and Death
mark.	Medical Examiner		resulting in death)	Due to (or	as a consequen	ice of):							V
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequen	ice off:						\rightarrow	
	red nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	\$.00 0.71							
	execu in and ial-tra	Ĕ	that initiated events resulting in death) Last	Due to (or	as a consequen	ice of):							
09	cate be executed physician and the burial-transit	dical		d									
6876	tificat ng ph as th	Mec	IF FEMALE:	1									
9 ×	eath certifical attending ph I for use as th	jan/	23b. Was decedent pregnant in the past 12 months?		th 2 🗌 Fetal d	eath 3	Ectopic pregnanc	y				ate of delive	
Вох	e deat the at ned fo	Physician/Me	1 Yes 2 No 9 Unknown	4 ∐ Pregnar 9 ☐ Unknow	nt at time of dea vn	ıth 5∟	Other (specify)				IVIC	onth	Day Year
P.O.	es that the des signed by the s be detached t		Part II. Other significant condition	ons contributing to deat	th but not resulti	ing in the u	nderlying cause giv	en in Part I.	,	23e. Did to	bacco use cont	ribute to th	ne cause of death?
S, F	signe signe d be o	Completed by								1 🗆 ነ	4.6		bably 4 🗆 Unknown
ord	require been si should b	lete								24a. Was a	n 24b.	Were auto	psy findings available
ecc	The law cate has page 2	шć								autop _ perfor	sy med?	prior to con death?	mpletion of cause of
<u> </u>	ician: The certificate ector, pag		25. Was case referred to medical				26 Pla	ace of Deat	h (Check	1 L Yes	2 DAINO	1 🗌 Yes	2 □ No
Vita	ysician: is certific director,	To Be	examiner? 1 ☐ Yes 2 █️No	Hospital:	patient 2 🗆 EF	R/Outpatier	Othe	P**		me 5 Resid	ence 6 Noth	er (Specify	nospice
of	ig Phy ter thi		27. Manner of De th	28a. Date of i		Bb. Time of injury		at		28d. Describe h			,
on	endin eath. or: Aff	fica	1 Natural 5 Pendir 2 Accident Investi	gation	Day, roar,	ii ij dii y		Yes 2	No				
Division of Vital Records,	or Atto	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inca 28e. Place of	Injury - At home etc. (Specify)	e, farm, stre	eet, factory, office			28f. Location (S: City or Town		er or Rural	Route Number,
Ö	Hospital or Attending Physician: The law requires that the death certificate be executed 424 hours after death. Funeral Director: Aleth this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transi												·
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	(Check 🙋 🔲 Medical B	Physician: To the best Examiner: On the basis of	of examination ar	nd/or invest	tigation, in my opinio	n, death oc	curred at	the time, date ar	nd place, and du	e to the cau	use(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practioner: To	the best of my kr	nowleage, c	29c. License		and place		cause(s) and mage		
	->-0		▶ (/ lesor	Un,			Do	50,2	30)	Augus	17	2010
			30. Name and address of person	who completed cause of	of death (Item 23	Ba) (Type, P	rint)	101			<u> </u>	-	
			MAKON J	CHA2	UES A	3	6701 N	CH	An	ies s	N TO	US01	V MU
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 9 2010	32. Regi	strar's Signature	1							

DHMH 17 Rev 7/2009

			For State of	Maryland				d Mental Hy		10	24789
		_	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L)eath		Reg. No.20	10	
	Physicia				M = -1-			2. Date of Dea	Day	Year	3. Time of Death
	Medic Examin		Anne Patri 4a. Facility Name (if not institution, give street and numb		Mack	4b. City, Town, or	Location of De	August	3, 201	ty of Death	3:00 p ^M
	Examin	er	Seasons Hospice				11stown			Baltim	ore
	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of Birt	h	g. Birthp	place (State or Foreign
	Director		216-44-0151 1 □ M 2 😾 F	66	Yrs.	Months Days	Hours M	in. Month Pay	1943	Coun Ma	ryland
	d wo	_	Usual Residence of Decedent 10a. State 10b. County	100 City	, Town or Loc	action					0.11.00.11.00
	rylan I-fsh ieda	cto		Toc. Oity,			h 0			'	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28g	Dire	MD Baltimore 10e. Street and Number			Reisters	LOWII		10g. Citizen of	NA/hat Caus	
	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show other, the Medical Examiner must be notified at	Funeral Director	3 Brookshire Driv	7e			136		U.S		iu y r
	ems ermu	in in	11. Marital Status 12. Was Decedi	ent Ever in U.S.	. 13. V	Vas Decedent of Hi	spanic Origin?	(Specify Yes or No-		ice - Americ	an Indian.
ڡ	ter de or it	by F	Armed Force 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2	X No	lf If	Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)	Bla	ack, White,	etc.
21215-0036	ural", ural",	ted	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Date		1	☐ Yes 2x No	Specify:		Specif	у: Б1	.ack
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occupa aind of work done of		vorking	16b. Kind of	3usiness Ind	dustry
7	within 7 giene. ner than t, the M	S	Elementary/Seconday (0-12) College (1-4	or 5+)		NOT use retired) autician			9	Salon	
	filed wit al Hygie d other event, th	Be (12 17. Father's Name (First, Middle, Last)		ье	aucician	18. Mother's N	Name (First, Middle,			
an	be fil ental ked ic ev	욘	Bernard H. Carter, S	ir			Ann			,	
Maryland	2 should be file lith and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type, Print)	, ,	19b. Mailin	a Address (Street a	-	Rural Route Number		State, Zip (Code)
Σ	d 2 sl alth a n 27 is ertra		Terry Louise Mack Daug	ghter	6 Ca	raway Roa	ad Apt.	3-B Rei	stersto	wn, M	D 21136
e e	of He fitem		20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from S		ace of Dispos	sition (Name of natory or other place	e)	Date	20c. Location	- City or To	own, State
Ĕ	Page ment ant: I ury o		4 ☐ Donation 5 ☐ Other (Specify)	tato	. Luke			10/10	Reiste	rstow	m, MD
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		21. Signature of Juneral Service Licensee	1/.		Name and Addres		11824 Rei			
	0 □ = a o	1 //	Slephen III g	enper		INE FUNE			rstown,	$\frac{\text{MD}}{2}$.1136
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each	used the death. I line.	. Do not ente	r the mode of dying	g, such as card	iac or respiratory arr	est,		Approximate Interval Between
	nysician/ Medical	n n	Immediate Cause (Final disease or condition resulting in death)	ina	Ca	ence					Onset and Death
	Examiner		Due to (or	ras a conseque	ence of):		1				
	15541	Jer	Sequentially list conditions, if any, leading to immediate Due to (or	r as a conseque	ence of):					_	
	rted ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury								
	execu an an ial-tra	Ë	that initiated events resulting in death) Last C. Due to (or	r as a conseque	ence of):		_		-		
g	cate be executed physician and s the bunal-transit	dical	d								
282	tificar ing ph	w	IF FEMALE:								
×	th cel ttend or use	ian/		rth 2 Tetal	death 3 [Ectopic pregnanc	у			ate of delive	ery Day Year
gox	e dea the a hed f	Physician/M	1 ☐ Yes 2 🕅 No 4 ☐ Pregna g ☐ Unknown 9 ☐ Unkno	ant at time of de wn	eath 5∟	Other (specify)				OTTET	Day Tour
л Э	hat th ed by detac	y Ph	Part II. Other significant conditions contributing to dea	ith but not resu	lting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
s,	uires t sign Ild be	ed by						_ 1 🗆 '	res 2□No	3 🗆 Prol	oably 4 Unknown
0	v requ	olete						24a. Was	an 24b.	Were auto	psy findings available
vital Records,	he lav te has age 2	Completed						autop perfo1 ☐ Yes	med? 2 X No	death?	mpletion of cause of
a	ian; T rtifica stor, p	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (C		Z WALINO	11	2 94 110
7	hysic his ce	2	1 Yes 2 No	patient 2 🗆 E	<u> </u>	t 3 🗆 DOA Othe	er: 4 🗌 Nursing	Home 5 Resid	ence 6 0th	ner (Specify	D'CL
10	ing P	ate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	injury , <i>Day</i> , <i>Year</i>)	28b. Time of injury	28c. Injury w <u>or</u> k	?	28d. Describe h	ow injury occur	red	
VISION	ttend death stor: / the 1	Certificate:	3 Suicide 6 Could not be	f Injuny - At hon	ne form etra	M 1 □ et, factory, office	Yes 2 No	OPE Lagation (C	ton at a said Missack	han an Donal	Deute Musebas
Ĭ	lor A after Direc d in by			, etc. (Specify)	ne, iaim, sue	et, lactory, office		28f. Location (S City or Tow		er or murai	Houte Nurriber,
_	ospita hours ineral d filled	Medical	29a. Certifier Certifying Physician: To the bes	st of my knowle	dge, death o	ccured at the time,	date and place	and due to the car	ise(s) and mani	ner as state	d.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Mec	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practioner: To								
_	To t		29b. Signature and title of certifier	5 - 1	no	29c. License	number	70	29d. Date signe	ed (Month, l	Day, Year)
			· caros of			701	35	10	Hug	usd	6, 201e
			30. Name and address of person who completed cause	of death (Item 2	23a) (Type, Pi	rint)	21	16	Jo a	, -	21061
	Stat	e.	31. Date filed (Month, Day, Year) 32. Rec	gistrar's ignatu	100	1	1 100	· · all			7001
	Registra	ır	31. Date filed (Month, Day, Year) 32. Reg	p. 19	parte						

Physician/ al Examiner	Registrar 1. Decedent's Name (First, Middle,Last)		ilicale oi	Death		Rec	. No. 201	0 24790	
	Larry Moore				3	2. Date of Death	Dav Year	3. Time of Death 1431 hrs	
	4a. Facility Name (if not institution, give stre 833 West Pratt Street Apt. # 6	· · · · · · · · · · · · · · · · · · ·	- 4	b. City, Town, or Lo Baltimore	ocation of Death		4c. County of Dea	ath	
Funeral Director	5 Social Security Number 6. Sex 218-42-1820	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth Sept 28	(MM/DD/YYYY) 9. I	Birthplace (State or Bign NOTEN CountryCarolina	
ow any	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number	-	own or Locati	on 10f. Zip Code		100	g. Citizen of What Co	10d. Inside City Limits 1 X Yes 2 No	
or items 23s or must be notified must be notified Funeral Dir	833 W. Pratt Stre	Was Decedent Ever in U.S Armed Forces? Yes 2 X No		21201 s Decedent of Hispses, specify Cuban, I	Mexican, Puerto R		USA 14. Race - Am White, etc. Specify: b1a		
Id be filed within 72 hours after mental Hygiens, arked other than "natural", event, the Medical Examiner, BE Completed by I	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	ates:	during mo	t's Usual Occupation ost of working life. It	n (Give kind of wo	er	medical	s/Industry facility	
permit. Pages I and 2 should be filed within 77 pearment of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	17. Father's Name (First, Middle, Lest) Burke Durrant 19a. Informant's Name/Relationship (Type, Leroy Hill — son	Print)		Address (Street a	e (First, Middle, Maiden Surname) Durrant Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 2121				
oernit. Pages I and 2 Department of Health a Important: If iten 2: Injury or other traum	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Apther Specify in State 21. Signature of Fund Service Licensee 22. Name and Address of Fecility 23. Name and Address of Fecility 24. Diseph H. Brown						20c. Location - City Baltimore	or Town, State	
xecuted n and l- transit cal Examiner	23a Part I. Enter the disease, of complication failure. List only one cause on each lir Immediate Cause (Final disease or con it is resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	ons that caused the death. I	o not enter the	55 W Ba: e mode of dying, su ovascular Dise	timore uch as cardiac or ase	Street; respiratory arres	Baltimore	Approximate Interval Between Onset and Death	
2 E E		c. If yes, outcome of pregna Live birth Pregnant at time of deat Unknown	2 Feth 5 Otr	al death 3	Ectopic pregnan	су	23d. Date of deliv Month	ery Day Year to the cause of death?	
The law requires that ficate has been signed page 2 should be deticable.	25. Was case referred to medical examiner?			26.Place o	f Death (Check or	1 Yes 24a. Was ar autopsy perform 1 Yes 2	2 No 3 Pi	robably 4 Unknown autopsy findings available o completion of cause of ? Yes 2 No	
Hospiral or Attending Physis Abous after death. Funeral Director: After this setely filled in by the funeral director for the funeral director.	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	i inpatient z L	R/Outpatient 28b. Time of Ir ne, farm, stree	njury 28c. Injury	at Work? 2	28d. Describe ha		Rural Route Number, City	
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	29a. Certifier 1 Certifying Physician: T (Check only one) 2 Medical Examiner: On t	(Specify) o the best of my knowledge he basis of examination and			•	lue to the cause	(s) and manner as st		
· 분 · 분 및		manner stated.		29c. License			29d. Date signed (A		

			For State Registrar	State of Maryland	-		t of Heal		lental Hyg F	giene Reg. No. 2 (010	24	791
B	Physici		1. Decedent's Name (First, Middle, Last) Edith MC (Sill		-,1			2. Date of Dea Month		Year 2010	3. Time of	Death M
	/Medio		4a. Facility Name (If not institution, give s Genesis Homewood	treet and number)			Town, or Loca 1timor			4c. Cour	ity of Death		
	Funeral Director		5. Social Security Number 6. Sex 242-36-1159 1□	7. Age (In yrs. lat	st birthday). Yrs.	If Under Months		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day May 2,	1926	9. Birthp Coun	lace <i>(State</i> o try) unk	or Foreign
	saryland show ed at	o.	Usual Residence of Decedent 10a. State 10b. County MD	,	Town or Local						1	0d. Inside Ci	-
	tn the N or 28a-1 e notifi	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen o	f What Cour	try?	
	ath wi		6000 Bellona Ave				1212			USA	Ameria	an Indian	
036	Z should be flied within 7/Z hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status unk 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? unk 1		Vas Deced fYes, spec 1 □ Yes 2		ic Origin? (Spi exican, Puerto ecify:	ecify Yes or No- Rican, etc.)	В	ace - Americ lack, White, cify: bla	etc.	
215-0	nthin 72 ho ne. han "natur e Medical I	Completed by	15. Decedent's Educ (Specify only highest grade	completed) College (1-4or 5+)	16a. Deced (Give life, L	lent's Usua kind of wor DO NOT us	al Occupation rk done during se retired)	most of work	ing	16b. Kind of	Business/Ind	dustry	
nd 2	be filed ital Hyg id other event, t	To Be Col	unk 17. Father's Name (First, Middle, Last)	unk unk			18.	Mother's Name	(First, Middle,	Maiden Surn	ame) unk	,	
lary	ges 1 and 2 should tt of Health and Men If Item 27 Is marke or other traumatic	F	19a. Informant's Name/Relationship (Typ			-			al Route Numbe	-			
6, ≤	Tand 2 Health a		Genesis Homewood 20a, Method of Disposition						Baltim Date	ore, M.			12
timor	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 🔀 Other (Specify)	in state	ace of Dispo metery, cren				te Anat			wii, otato	
Bal	Deparent Important any ir conce.		21. Signature of Funer Service License ROna I.d	fide, Director	22				Street;	-		MD 212	201
	Physician /Medical Examiner	285	23a. Part 1 Enter the disease, or complication shock or heart failure. List only on Immediate Cau 1 Final disease or condition resulting in death)	cations that caused the death. le cause on each line. ATHEROS Due to (or as a conseque	CLER		_			Page	ASE	Approximat Interval Bet Onset and	Death
	ate be executed hysician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque									
68760,		dical	d										
. Box	that the death certific led by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of de: 9 ☐ Unknown	death 3	Ectopic pr Other (sp				1	Date of delive Month		Year
Δ.	8 5 9	by	Part II. Other significant conditions con	tributing to death but not resul	ting in the u	nderlying c	ause given in	Part I.		obacco use co Yes 2 □ No		ne cause of o	
l Rec	The law ate has b page 2 s	Completed							24a. Was autor perfo 1 Yes	an 24 osy rmed? 2 DNo	death?	psy findings mpletion of c	available cause of
/ita	stcian: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	lospital:			Louis		h (Check only o				
or	S S	٦.	1 Yes 2 10 10	1 Inpatient 2 E	R/Outpatier 28b. Time o			Unursing Ho	ome 5 Resident			(y)	
sion	Attending r death. ector: After by the fune	ation	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □ No				_	
É	i di te o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	me, farm, str)	eet, factory	y, office		28f. Location (S City or To		mber or Rura	al Route Nur	mber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical		sician: To the best of my know ner: On the basis of examinati and manner stated.									s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7-11		290	c. License nur	mber		29d. Date sig	ned (Month,	Day, Year)	
			30. Name and address of person who co	moleted cause of death (Item	23a) (Type	Print)	23/	136		AUGU	57 3	201	0
			BRIAN C-W	mpleted cause of death (Item. ALLACE, MS) 32. Registrar's Signate	900	05 14	ICBA	DE R	D, BAC	TIMOR	25, ms	> 212.	36
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signati	par	las							

			For 1 _ State	State of		d / Depa	artment of F rtificate of I	lealth and I	•	giene 2		24792
	Physici	an.	Registrar 1. Decedent's Name (First, Middle	e, Last)			uncate or i	Dealii	2. Date of De			3. Time of Death
	/Medic		Olive Mary Mur						July	29 Day	2010	3:55 A M
` .	Examir	ier	4a. Facility Name (If not institution	-	er)			Location of Death	n		ity of Death	_
-	Francis	_	5315 Glen Fall 5. Social Security Number		Age (In vrs.	last birthday)	Reiste:	If Under 24 Hrs.	8. Date of Bir		Ltimor	e blace (State or Foreign
	Funeral Director		119-16-5424 Usual Residence of Decedent	1□M 2⊠F	84	Yrs.	Months Days	Hours Min.	Dec 27,	1 ⁹ 25	New .	Jersey
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Mary F-f sh	į	MD Balt	imore	R	eister	stown					1 ∐Yes 2X∑No
	or 28	Director	10e. Street and Number	•			10f. Zip Code			10g. Citizen o	f What Coun	itry?
	23a c	ᆵ	5315 Glen Fal	ls Road			21136			USA		
36	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, I've Medical Expriner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 ☒ Divorced	If Yes, Give	es? K]No		Was Decedent of H f Yes, specify Cuba l □Yes 2☑No	ispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		ace - Americ lack, White, e	etc.
8	hour tural		15. Deceden		es: 	16a Dece	dent's Usual Occup	ation		16b. Kind of	Business/Inc	duetry
Maryland 21215-0036	should be filed within 72 nd Mental Hygiene. marked other than "na imatic event, the Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	College (1-4	or 5+)	(Give life. I	kind of work done of NOT use retired	during most of wor d)	king	Balt		County
2		Be C	17. Father's Name (First, Middle,			1	-1-8-1	18. Mother's Nam	ne (First, Middle			
<u>Jar</u>	should be and Mental s marked o	To B	Edward Pritcha	ard				Olive N	Mulready			
, Mar)	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Once.		19a. Informant's Name/Relations Edward Murdy				ng Address (Street 9 Allan :					
Baltimore,	Pages 1 a ent of He nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (€)		1 ^	Place of Dispo emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location	n - City or To	wn, State
Balti	permit. I Departm Importar any inju		21. Signa ure suneral Service		rector	c 22	Name and Addres					MD 21201
	Physician and Asician and Pricial Examiner	cal Examiner	23a. Parki. Enter the disease, or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	as a conse u	uence of):	er the mode of dyin	.]	tor respiratory a	rrest,		Approximate Interval Between onset and Death
/89	ficate physics the l	edic	a	d								
C. Box	w requires that the death certificat s been signed by the attending phy should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal nt at time of d	Idéath 3□	Ectopic pregnancy Other (specify)	<i>y</i>		6.00	Date of deliver Month	ery Day Year
JS, T.	requires that the reen signed by th rould be detache	þ	Part II. Other significant condition	ons contributing to deat	h but not resu	ulting in the ur	nderlying cause give	en in Part I.				ne cause of death?
000 000	v requ been should	eted	Charic	COPO	10.	1101	0000	101190	1 🗆 '	_		
H H	The la ate has page 2	Completed	CHOME	W. C.	101				24a. Was autoj perfo 1 □Yes		prior to cor death? 1 ☐ Yes	psy findings available mpletion of cause of 2 □ No
VITA	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			• a 🗆 Doa Othe	26. Place of Dea	7			
5	y Physer this eral di	۲. T	1 ☐ Yes 2 ☑ No 27. Manyer of Death	1 ∐ Inp	njury	ER/Outpatien 28b. Time of	T 3 DOA	4 LI Nursing H	ome 5 Resi			/)
0	nding ath. r: Afte e fune	aţio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investig		Day, Year)	Injury	28c. Injury Work	? Yes 2 □No		,,		
DIVIS	al or Atte s after des al Directo ed in by th	Certification: To	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	Land Zoe, Place of	Injury - At ho etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (: City or Tox	Street and Nun vn, State)	nber or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physician: To the be Examiner: On the basi and manner	s of examinat	wledge, death	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the arred at the time,	cause(s) and i	manner as s e, and due to	tated. the cause(s)
	Vith Com	M	29b. Signature and title of certifier	141		\	29c. License	number	0	29d. Date sign	ned (Month,	Day, Year)
			P	ZU Vaalu	un)		4760	8	081	021	2010
			30. Name and address of person	who completed cause of	of death (Item	23a) (Type, I	Print)	Thilon	7 1	4 1	11	11.

State Registrar

31. Date filed (Month, Day, Year)

AUG 0 9 2010

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) Physician Margaret Ann Oswinkle /Medical Facility Name (If not institution, give street and number) **Examiner Funeral** Months 1 □ M 2 🕱 F 83 215-24-1502 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Essex 10e. Street and Number 102 Bennett Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status 1 □Yes 2

if Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXVIo 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental မ Henry Walters 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trauonce. Joseph C. Oswinkle, Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of paperal Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final **Physician** disease or condition re-ulting in death) /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as e consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached f 1 ☐Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Division of Vital Records, this certificate has been page 2 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this y filled in by the funeral di 27. May er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death Reg. No U 2. Date of Death MA OIFO 2010 4c. County of Death 4b. City, Town, or Location of Death Rosedale Battimore 8. Date of Birth (Month, Day, Year) 07/22/1927 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Min. Days Hours Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2XXVIo 10g. Citizen of What Country? 10f. Zip Code 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify. White 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home 18. Mother's Name (First, Middle, Maiden Surname) Margaret Ann Giveny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 Bowleys Quarters Road, Baltimore, Maryland 21220 20c. Location - City or Town, State Date 08/11/2010 | Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 4 🗹 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform rmed? 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) RESOUU

10 v

DR. Alexis

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 9000 Franklin Square Drive Baltimore, MD 2123-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Doris June Russell AM August 2010 9:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 814 Arncliffe Rd. Baltimore Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 😾 F Hours (Month, Day, Year) August 27 67 Maryland 212 42 8132 Director 1942 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director Maryland Baltimore Essex 1 ☐ Yes 2 🔀 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 814 Arncliffe Rd. 21221 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 9 δ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: "natural" 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Home Caregiver Home Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter E. Russell Catherine Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Stevenson (Niece) 814 Arncliffe Rd. Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Bayview Crematory Inc. 8/10/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Avenue Essex Maryland 21221 23a Prit 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest snock, or heart failure. List only one cause on each line. Approximate Interval Between SISORd Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death ed by the a detached i Yes 2X No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 1 Yes No 3 Probably 4 Unknown been signated the should the Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🔲 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month) 30/Name and address of person who venue < wuma

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day-Year) - ----

State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Reg. No. 2010 24										
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) Tiffany M Schu	2. Date of Death Month Day July 13, 2010	Year 3. Time of Death 1102 hrs							
	4a. Facility Name (if not institution, give street and not 1817 South Charles Street	umber)	lb. City, Town, or Location of Deat Baltimore		c. County of Death					
Funeral Director	5. Social Security Number 6. Sex 213–31–0189	7. Age (In yrs. last birthday) 21 Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Mir		9. Birthplace (State or Foreign Country) MD					
v any	Usual Residence of Decedent 10a. State	10c. City, Town or Locati			10d. Inside City Limits					
the Maryland a or 28a-f sho iffied at once. Director	10e. Street and Number 2516 James Street		Baltimore City		1 X Yes 2 No No tizen of What Country?					
outh the M s 23a or 2 s notified		cedent Ever in U.S. 13. Wa	21230 Decedent of Hispanic Origin? (\$	necify Ves or No-	USA 14. Race - American Indian, Black,					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed F 1 Yes 3 Widowed 4 Divorced If Yes, Give Yes or Dates. 15. Decedent's Education (Specify only highest grants)	orces? If You are 1	es, specify Cuban, Mexican, Puerto Yes 2 No specify:	Rican, etc.)	White, etc. white Specify:					
5-0036 led within 72 hour bygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (10 0 0	during mo	's Usual Occupation (Give kind of ist of working life. DO NOT use ret		Food Service					
21215-0036 wild be filed within 77 Mental Hygiene. marked other than c event, the Medical fo Be Comple	17. Father's Name (First, Middle, Last) John J. Schuyler	e (First, Middle, Maiden a M. Russe	11							
MD 21 12 should th and Me 127 is ma umatic ev	19a. Informant's Name/Relationship (Type, Print) John J. Schuyler / Fat	Rural Route Number, C Baltimore N	City or Town, State, Zip Code) MD 21230							
ilmore, MD Pages I and 2 sho ment of Health and tant: If iten 27 is or other traumati	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fr 4 Donation 5 Other Specify:	20c. Location - City or Town, State Hanover Maryland								
Baltimo permit. Pages Department o Important: i	21. Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, I. 1501 East Fort Avenue, Baltimore M									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone Intoxication									
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):									
60, tte be executed tysician and e burial - transit Aedical Examine	cause. Enter Underlying Cause	consequence of):								
60, tte be executed thysician and e burial - transit	d		,27,28a-f per me	2006 Q_19	2_10_vrt					
'60, ate be er ohysician te burial	IF FEMALE: 23c. If yes, (outcome of pregnancy	,27,20a-r per me		d. Date of delivery					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. In Elemental Director: After this certificate has been signed by the attending physician and appliedy filled in by the funeral director, page 2 should be detached for use as the burial - transilical Certification: To Be Completed by Physician/Medical E.	23b. Was decedent pregnant in the past 12 months?	irth 2 Feta ant at time of death 5 Oth	al death 3 Ectopic pregna er (Specify)		Month Day Year					
P.O. es that the igned by ti	Part II. Other significant conditions contributing to	death but not resulting in the ur	derlying cause given in Part !.	I	use contribute to the cause of death? No 3 Probably 4 V Unknown					
of Vital Records, ng Physician: The law requires ther this certificate has been signeral director, page 2 should be 7: To Be Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
ital Rician: Tiction: Ector, pg	25. Was case referred to medical examiner?		26.Place of Death (Check		0 10 2 10					
F Vit Physic er this eral dire	examiner? 1 V Yes 2 No 27. Manner of Death 28a. Date	npatient 2 ER/Outpatient of Injury 28b. Time of In		ng Home 5 Reside	ence 6 Other: Scene					
ion of Vending Pheath. or: After the funeral attion: T	1 Natural 5 Pending (Month,	Day, Year) -13-10 fd 10:3	4 N 2 N	unknown	ary occurred					
Division o spiral or Attending nours after death. filled in by the fune Certification:	3 Suicide 6 X Could not be determined (Specify)	e of Injury - At home, farm, street			and Number or Rural Route Number, City 1817 S. Charles St.e, Md.					
To the Hos within 24 h To the Fur completely	29a. Certifier 1 Certifying Physician: To the bes (Check only one) 2 ✓ Medical Examiner; On the basis of management and management of the part of management of the control of the basis of the part	of examination and/or investigation								
To with To con	29b. Signature and title of certifier	alcu.	29c. License number		Date signed (Month, Day, Year)					
	Jamely Ryushulls Mil. 30. Name and address of person who completed caus	e of death (Item 23a)	O.C.M.E.	July	/ 14, 2010					
			Penn Street, Baltimore, M	MD 21201						
State Registrar	31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature								

			For State Registrar		State of N	Maryland	-	irtment of <i>tificate o</i>		nd Mental H	ygiene Reg. No	2010	24796	
	Physicia	212	1. Decedent's Name (F	irst, Middle, Last	")					2. Date of D Month		Year	3. Time of Death	
	/Medic			Theresa	Stone					Augus			6:15 PM	!
	Examin	er	4a. Facility Name (If no	_		er)		4b. City, Town	, or Location of I	Death		County of Deat		
	Funeral		Riverview C 5. Social Security Numb			Age (In yrs. I	ast birthday)	If Under 1 Ye		Hrs. 8. Date of B			thplace (State or Foreig	jr
	Director		220-16-3277	7 10	⊒м 2 ХС Х∓	85	Yrs.	Months Day	/s Hours	Min. 10/26	/1924	Mar	ryland	
	p >		Usual Residence of De	cedent b. County	<u>'</u>	100 City	, Town or Lo	action					10d. Inside City Limits	_
	larylan show	ō		,	_		idle Ri						1 ☐ Yes 2 🕱 No	
	28a-1	rect	Maryland E	Baltimore	е	MIC	idte Ki	10f. Zip Cod	9		10g. Citi	zen of What Co	untry?	_
	3a or	a Di	2233 Southo	orn Road				2	21220		U	.S.A.		
	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, it is Medical Exa. if wer must be notified at	Funeral Directo	11. Marital Status		12. Was Decede Armed Force		S. 13. \	Vas Decedent of Yes, specify C	of Hispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Ame Black, White		_
20	or ite	by Fu	1 ☐ Never Married 3 ☐ Widowed 4		1 □Yes 2[If Yes, Give	X No		□Yes 2⊠1		derio modify erosy		Specify: Whi	•	
2-00-c	hours tural"			J Divorced Decedent's Edu	Year or Date	s:	16a Decer	lent's Usual Oc	cupation			WITI nd of Business/		
Ċ	in 72 n "na nedic	Completed	(Specify o	only highest grad	le completed)		(Give life. L	kind of work do OO NOT use ret	ne during most o ired)	of working		na or Basinoss	made.ry	
7	filed within Hygiene. other than "	E O	Elementary/Seconda	19 (0-12)	College (1-4d	n 5+)	Homen	aker			Ow	n Home		
and	be file tal Hy d othe	Be	17. Father's Name (First							s Name (First, Midd	le, Maiden	Surname)		
<u>X</u>	hould be nd Menta marked matic e	ပ္	Clarence Ea							Storm				_
Mar	permit. Pages 1 and 2 should be Departiment of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		19a. Informant's Name Shirley Ann			r)				or Rural Route Num Baltimor				
ā,	Heal tem 2		20a. Method of Disposi		(sition (Name of natory or other)	<u>·</u>	Date	,	cation - City or		-
<u>e</u>	Pages ent of nt: If i		1 M Burial 2 □ C 4 □ Donation 5 □			ITA I				8/09/2010	Litt	lestowr	ı. Pa.	
paltimo	mit. F partm portal y injul		21. Signature of Funer			>				ski Funer				_
מ	9 E E G		1			>	1	407 old	Easter	n Avenue,	Esse	x, Mary	land 21221	_
			23a. Part 1. En the c shock heart fa	disease, or compl allure. List only o	lications that caus ne cause on each	sed the death n line.	n. Do not ent	er the mode of	dying, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death	
. +	Physician		Immedia e Cause (Final disea or condition resuling in death)	al	a. Ces	reby	ovas	cular	acci	dent			Oriset and Dean	
	/Medical Examiner		resuming in death)		Due to (or	as a consequ	ience of):							
		-e	Sequentially list conditi	ions,	b. Due to for	Lemon a BB	ence of):							_
	uted d ansit	Examiner	Sequentially list condition any, reading to infractional cause. Enter Underlyin Cause (Disease or injuthat initiated events	ng iry	1-1-	. 1	enlic	~						
Ď	execan an an rial-tra		resulting in death) Last	t 📳	Due to (or	as a consequ								
8/00,	Physician, The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	dical			d. Chro	MIC.	obed	uetre	pur	novary	due	oce		_
ŏ	ertific ling p e as t	Med	IF FEMALE:	-	00 1/	COTTO NO.			V					
Š D	attend for us	Physician/Me	23b. Was decedent pre in the past 12 mon	nths?		me of pregna h 2□Fetal nt at time of d	death 3	Ectopic pregn			1	23d. Date of de Month	livery Day Year	
j	the de	ıysic	1 ☐ Yes 2 X No 9 ☐ Unknown	0	9 ☐ Unknow		eam 5L	Other (specify)					
Ţ.	that the		Part II. Other significal	nt conditions co	ntributing to deat	h but not resu	ılting in the u	nderlying cause	given in Part I.	23e. Die	d tobacco u	ise contribute to	o the cause of death?	
ecords,	quires en sigi uld be	ed by								1[Yes 2	□No 3□P	robably 4 Unknow	n
ည သ	aw re as bee 2 sho	Completed								24a. Wa		24b. Were a	utopsy findings availabl completion of cause of	e
ř	The I	Com			-					— au pe 1 □ Yes	topsy rformed? 2 2 No	death?	s 2 \square No	
N I G	cian; ertific	Be (25. Was case referred examiner?							of Death (Check only				_
5	Physi this o	ည	1 ☐ Yes 2 No	100000000000000000000000000000000000000		atient 2		T 3 DOA		sing Home 5 Re			ecify)	_
5	ding I J. After funer	ertification:		Pending investigation	28a. Date of I (Month,	Day, Year)	28b. Time of Injury		njuryat Vork? I∐Yes 2∐No	28d. Describ	e how injur	y occurred		
VISION	Atten deatl ctor: y the	ficat		Could not be determined	28e. Place of	Injury - At ho	me, farm, str	eet, factory, office			(Street an	d Number or R	ural Route Number,	-
5	al or / s after il Dire	Certi	4 ☐ Homicide	determined	building,	etc. (Specif)	/)	-		City or T	own, State)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical (s of examina				place, and due to the occurred at the time				
	To th withir To th comp	Me	29b. Signature and title	of certifier				29c. Lic	ense number		29d. Da	te signed (Mon	th, Day, Year)	
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•	31		30. Name and address	tion K	John	30	23	Print) Easte	vn Av	renne l	Rolt	more	21224	
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DU	Registr	ar	A	100 0 7 2	UIU A		1. 1							_

George William Smith

State of Maryland / Department of Health and Mental Hygiene

<u>J</u> .		1- For State Registrar		tificate of Dea		7.5	2010 eg. No.	24191
Physici //edical Exam		Decedent's Name (First, Middle,Last)	Cas			2. Date of Deat Month	Day Year	3. Time of Death 1140 hrs
meulcal Exami	iilei	George William Smith, 4a. Facility Name (if not institution, give street and number)		4b. City	, Town, or Location of D	August 4,	4c. County of Deat	
		2 James Street Apt. 1A		Fred	derick		Frederick	
Funeral		5. Social Security Number 6. Sex 7. Ag	je (In yrs. la	Mon	ths Days Hours	Min	th(MM/DD/YYYY) 9. Bir Forei	n
Director		214-10-3119 1 M 2 F		93 Yrs.	Days Hours	Feb.	3, 1917 c	untry)Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
nd show a	ŗ	Maryland Frederick			Frederick			1 X Yes 2 No
Maryla 28a-f d at or	Director	10e. Street and Number		10f. Z	ip Code	10	0g. Citizen of What Cou	ntry?
with the Maryland ms 23a or 28a-f show any be notified at once.		2 James St., Apt. 1A			2170		U.S.A.	<u></u>
ath wi items	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces	?		dent of Hispanic Origin? cify Cuban, Mexican, Pu		- 14. Race - Amer White, etc.	ican Indian, Black,
fter de I", or i		3 Widowed 4 Divorced If Yes, Give Year or Dates:	No	1 Yes	2 X No specify:		Specify:	White
nours a	ed by	15. Decedent's Education (Specify only highest grade cor			al Occupation (Give kind		16b. Kind of Business/	Industry
36 in 72 h	plet	Elementary/Secondary (0-12) College (1-4 or 2	5+)	· ·		,	hanleina	
5-00; ed with ygiene offier t	Completed	17. Father's Name (First, Middle, Last)	1	Danker /	president 18.Mother's N	ame (First, Middle, M	banking Maiden Surname)	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Raymond Lee Smith					ne Cutshall	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ဌ	19a. Informant's Name/Relationship (Type, Print)					ber, City or Town, State	
MD and 2 sho lealth and item 27 is		G.W. Smith, Jr./ son 20a Method of Disposition		lace of Disposition (Na		Date	rsville, MD 20c. Location - City or	
Baltimore, permir. Pages I an Department of Hea Important: If itel		1 X Burial 2 Cremation 3 Removal from St	ale	rematory or other place. Hope Cen	<i>'</i>	8/9/2010	Woodsbor	O. MD
altir mit. P partme portan ury or	1 5	4 Donation 5 Other Specify: 21 Sig ature of Funeral Service Licens	7		d Address of Facility	artzler Fi	neral Home	O / 1110
	ir i	Cathaire U. Harz	an	404 S.	MainSt.	Woodsboı	ro, MD 2179	8
Physician		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.			e of dying, such as cardi	ac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunsho						Bodui
		Sequentially list conditions, b.						
	amine	if any, leading to immediate Due to (or as a consecutive Enter Unachyina Campanian Cam	aquence of):				
ed nsit	Exar	(Disease or injury that initiated events resulting in death) Last Due to (or as a const	equence of	():				
760, cate be executed physician and the burial - transit	Medical	d d AMENDED						
760, cate be exc physician the burial -		IF FEMALE: 23c. If yes, outcor	ne of pregr	nancy			23d. Date of deliver	
Box 687 death certific the attending of for use as the	sician	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at	time of dea	2 Fetal death		egnancy	Month [Day Year
Box e death the atte	Physi	1 Yes 2 No 9 Unknown 9 Unknown		- Canar (a)				
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to death	n but not re	esulting in the underlying	ng cause given in Part I.		bacco use contribute to 2 ✓ No 3 Prof	
ds, Fauires								topsy findings available
COF	ompleted			-		autops	med? death?	completion of cause of
Vital Rec ysician: The l his certificate l director, page	ပ	25. Was case referred to medical			26.Place of Death (Ch	1 ✓ Yes 2	2 No 1 Y	es 2 No
Vita hysician this cer direct	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatie	ent 2	ER/Outpatient 3	Othor		Residence 6 🗸 Othe	Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	L ii	27. Manner of Death 28a. Date of Inju	ıry 'ear)	28b. Time of Injury FOUND:	28c. Injury at Work?	Subject shot	ow injury occurred	
Sior Attend r death ector: by the	catic	2 Accident Investigation Aug 4, 2010		1130 hrs me, farm, street, factor	1 Yes 2 No		treet and Number or Ru	ral Pouta Number City
Divising the spital or At the cours after divided in by filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Mu			y, office building, etc.	or Town, St		
Hospi 24 hou Funer rtely fil		29a. Certifier (Check only 1 Certifying Physician: To the best of m		-10	ne time, date and place,			
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated	mination an			red at the time, date a		
	Σ	29b. Signature and life of certifier	/n	1850 25	9c. License number O.C.M.E.		29d. Date signed (Mo August 5, 2010	nth, Day,Year)
		30. Name and address of person who completed cause of c	teath (Itom	23a)	O. O. IVI. L.		August 5, 2010	
		Victor Weedn MD JD Assistant Medical			Street, Baltimore, N	MD 21201		
S	ate	31. Date filed (Month, Day, Year) 32. Resistra	₹s-Signatur	re I L W	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August Jack Milton Stowe 2010 10:42 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs Social Security Number . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Hours ine 24, Year) North Carolina 237-38-6688 81 Director June Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Chester Queen Annes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21619 1808 Stevens Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No 1947-Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced 1948 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Willima Stowe Winnie Elizabeth Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stevens Drive; Chester, Maryland 21619 Rita Stowe - wife Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Ronald, S 22. Name and Address of Facility State Anatomy Board Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as monsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying uman Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the extending the control of the Funeral Director. been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🖺 No Other: 1 Yes Certificate: To 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be

State Registrar

Medical

4 Homicide

29a. Certifier

(Check

31. Date filed (Month,

з 🗌

29b. Signature and title of certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ridg

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

20

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

0-05449	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 2479													
lelanie Smith		1- For State Registrar			•	ertificate			id Mentai		Reg. No	201		24799
Physici Medical Exami		1. Decedent's Name (Fi		,Last)						2. Date of D Month July 21,	Day	Year	3	3. Time of Death 1347 hrs
		4a. Facility Name (if no	t institution	, give street and nu	mber)				r Location of Dea		4	tc. County of D		
Funeral		6513 Loch Hill 5. Social Security Number		S. Sex	7. Age (In yrs	. last birthday	Tows	der 1 Yea	ar If Under 24h	Irs. 8. Date of		M/DD/YYY) 9		
Director		214-84-02	.09	1 M 2 F		1	Yrs. Mont			lin. Dec		1958 ^F	oreign Coun	_{try)} Mary1and
any		Usual Residence of Dec 10a. State 10b	cedent c. County		10c. Cit	ty, Town or L	ocation						1	0d. Inside City Limits
and show	ō	MD	Balt	imore	Т	owson								1 Yes 2 No
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	10e. Street and Number		1 Count				p Code 1239			1	itizen of What	Countr	y?
with the s 23a o e notifi		6513 Loc 11. Marital Status	:u ull		edent Ever in	U.S. 13.			spanic Origin? (Specify Yes or			merica	n Indian, 8lack,
death v	Funeral	1 Never Married	2 Mar	ried Armed Fo	orces?				n, Mexican, Pue			White, e	ic.	
rs after ural", o	by	3 Widowed 4		rced If Yes, Give Yea or Dates:		1 162 Doce			specify:	f work done	1166	Specify: W	hit	
72 hour n "natu	eted	Elementary/Seconda		College (1					e. DO NOT use r		100.	Killa of Basilii	255/1110	iusii y
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (Firs Salvatore		•					18.Mother's Nar Mary	ne (First, Middl [heresa				
2121 hould be find Mental is marked tric event,	ToE	19a, Informant's Name/i					_		et and Number o			-		•
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JOFe ages 1: nt of H nt: If it	П	1 Burial 2 0	Cremation	3 Removal fro	om State		r other place							
altin mit. P partme portan ury or	202. Location - City or Town 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 XOner Specify: in State 21. Sign re of Euneral ryice Licen day Director 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Donation 5 XOner Specify: in State 25. Name and Address of Facility 26. Director													
		allm	1/	inde			655 V	W. B.	atimore	Street	; Ва	ltimore	, M	D 21201
Physician /Medical		23 . Part I. Enter the di failure. List only or	ne cause o	n each line.						or respiratory	arrest, sr	nock, or near	1	Approximate Interval Between Onset and Death
Examiner		Immedi Use (Fina or condition resulting in		a. Acquir Due to (or as a	consequence	of):							\dashv	
	<u>.</u>	Sequentially list condition		b. Human Due to (or as a			ency \	Viru:	s Infect	ion			-	
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xecuted 1 and - transit	Exa	events resulting in deat	th) Last	Due to (or as a d.	consequence	of):								
oe execut cian and riial - tra	dical	X UNPENDED		AMENDED	23a,b,	27 per	me g	907	9-8-10 v	7t				
Box 68760, death certificate be ex the attending physician of for use as the burial.	/Me	IF FEMALE: 23b. Was decedent preg	nant in the		outcome of pre		Fetal death	3	Ectopic preg	nancy	23	3d. Date of deli	very	y Year
X 68 th certi ttendin r use as	iciar	past 12 months?		4 Pregna	ant at time of o	leath 5	Other (Spe			nancy		WOTH	Day	, i eai
b. Bo the deat by the at	Physician/Medic	1 Yes 2 No 9		Ja Olikilo		resulting in ti	ne underlying	a cause o	given in Part I.	23e. Dio	tobacco	use contribute	e to the	e cause of death?
ires that the signed by the detache	ğ								3	1 🔲 ነ	es 2	No 3	Probab	oly 4 🗸 Unknown
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be en 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician lely filled in by the funeral director, page 2 should be detached for use as the burial	Certification:	3 Suicide 6	Could	not be 28e. Place	of Injury - At	home, farm, s	treet, factory	y, office b	ouilding, etc.	28f. Location or Town		and Number o	Rural	Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Cert		sician: To the besi		-								ausa/s)
To the within comp	Medical	29b. Signature and title		and manner st		androi invest			e number	Tat the time, da		Date signed		
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		30. Non address of	•				100							
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St Regist	6466	31. Date filed (Month, Da	ay, Year) \begin{align*} \begin{align*} ali		gistrar s Signa	Je As	Med			OCME				

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32. Registrar's Sigrature

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SURESU 31. Date filed (Month, Day, Year) 101

FORT WASHINGTON

State 31. Date filed (Month, Day, Year)
Registrar AUG 0 9 201

Margarita Korell MD

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:00 AM Dorothy Lois Teipe 01 AUC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Levendale Nursing Home Reisterstown 5. Social Security Number . Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Oc^{(Month}, 20, Year) 927 9. Birthplace (State or Foreign **Funeral** 1 - M 2 XF Days Hours 82 Martyland 215-24-3280 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1- Yes 2 X No Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 21229 1021 St. Charles Avenue ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 🗓 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Yes. Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 hof Health and Mental Hygiene. item 27 is marked other than "nother traumatic event, the Medi College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Slater Charles Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 S. Carolina Ave., Pasadena, MD 21122 Dorothea Ann Ganz - Daughter item 2 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donat on 5 ☐ Other (Specify) MD Cererans Cemetery Clarrison Forest Owings Mills, MD 8-9-2010 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signature of Liner Service Li 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Ph sician/ Acute MOUY Medical resulting in death) Examiner neonly Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burial the attending physician hed for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) 1 ☐ Yes ∠ up g ☐ Unknown Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 prior to completion of cause of death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 🗙 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Npatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accider (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the wine, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar

(or

BELVEDERE AVENUE, BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 0 9 2010 D0053928

SURAIYA

08/02

12010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24803 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month August 6, James Carroll Tolan 5:32 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Towson Gilchrist Hospice . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Month, Day, Ye Months Days Hours Min. 1 X M 2 A F Yrs 1953Washington, D.C. Director 166-44-9804 56 Sept Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 9 A South Lake Way 21136 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 9 by 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Exami 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Psychology Psychologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry Tolan Anita Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karyn H. Tolan Wife 9A South Lake Way Reisterstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department or Important: If any injury or 8/11/2010 4 ☐ Donation 5 ☐ Other (Specify) Saints Cemetery Reisterstown, MD 22. Name and Address of Facility 11824 Reisterstown Road neral Seraice Licensee Signature ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition one you Medical resulting in death) Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate E term of the cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death g 🗌 Unknown Be Completed by

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Certificate: To

art II. Other significant conditions co	ontributing to death but not re	23e. Did tobacco use contribute to the cause of death?				
				1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
				24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No		
5. Was case referred to medical examiner?			26. Place of Death (Chec	ck only one)		
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 \(\sum \) Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify) WS DWQ		
7. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif		8f. Location (Street and Number or Rural Route Number, City or Town, State)			

only one) and title of certifier

AUG 09

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d, Date signed (Month, Dav. Year)

2000

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

State Registrar

Medical

29a. Certifier (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month & Day 5 5 Physician/ ATHLEENE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** ried e nna 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth 7. Age (In vrs. last birthday) Funeral Min (Month, Day, Year) 12/02/192 Days Hours 355-14-0167 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f shov 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at **Funeral Director** Page 1 and 2 should be filed within 72 hours after death with the Maryland MD Annapolis A.A 1 ☐ Yes 2 🔀 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21012 2546 North Haven Cove USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XXIII þ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 TNo Specify. 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Public Library 5+ Librarian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Lydia Zimbelman ပ္ Jacob Potteiger other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 1524 Gordon Cove Dr Annapolis MD 21403 Daughter Jane Weizmann of Health a item 27 i Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 K Cremation 3 Removal from State 8/7/2010 Glen Bernie MD Atlantic Crem 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Thomas Allenpa 7090 Ridge RD Hanover MD . Signature of Euneral Service Licensee CI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Knowney Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consi quence of) Examine as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 /es, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

☐ Compared at time of death 5 ☐ Other (specify) ____ IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year g Unknown 9 Unknow Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 🗌 Yes No 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performes page 2 🗌 No Yes 1 🗌 Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 4 Nursing Home 5 Residence 6 Other Specif Other: 1 Inpatient 2 ER/Outpatient 3 DOA ပ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Derth 28c. Injury at Certificate: injury work? 1 Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director:
completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 052830 August carrise werry 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tgate Road #300, Annagolic,

State Registrar 31. Date filed (Month,

900 Bes

32. Registrar's Signature

Werne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#6,22perFH,G906,8/9/2010 WS
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Komas Watkins 6:20.4M August 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchvist Hospice lowson Battimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 **X** м 2 Ст 238.32.4649 Days Hours Months Min. NC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Baltimore MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 Funeral Columbus USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: Back 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Steel Worker 12th grade NIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Swnes Elna Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fearly Pickett Watkins/Wife Columbus Drive Baltimore MD21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Dwings Mills, HD 08/12 10 . Signature of Funeral Service Licenses 22. Name and Address of Facility -Vaughn C. Greene Funeral Svcs. au Road + Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician Pancreatic Cancer disease or condition month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 L 9 \ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by my cloma, Spinal cord compression 1 Yes 2 No 3 Probably 4 Unknown tract infection 24b. Were autopsy findings available prior to completion of cause of death? Minary 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Wo Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my policy death occurred. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 70635 MO 8/6/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pate St Baltimore, MD 01 Charles 31. Date filed (Month, Day, Year, 32. Registrar' Signatu State AUG 0 9 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar		Cer	tificate of L	Death		eg. No. 2	2010	24806
	Physicia		1. Decedent's Name (First, Middle, Las HOWARD	WHITE				2. Date of Deat Month AUGUST	Day	Year Zolo	3. Time of Death 2: 40 P M
E.	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give NORTH WEST 5. Social Security Number 6. S 1	- KOSPITAL		4b. City, Town, or A If Under 1 Year Months Days	Location of Death ALLS 7 If Under 24 Hrs. Hours Min.	TOWN	Year)	Cour	lace (State or Foreign
	ow II		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				1	0d. Inside City Limits
	e Mary la-f sh	Director	MD Balti	more	R	eisterst	own				1 □Yes 2 No
4	a or 28		10e. Street and Number	٠		10f. Zip Code	136	1		n of What Cour	ntry?
-	be filed within 72 hours after death with the maryland intal Hygiene. In whatural", or items 23a or 28a-f show event, it a Modical Exempter must be notified at	Funeral	606 Piper Roa	12. Was Decedent Ever in U. Armed Forces? 1	S. 13. V	Vas Decedent of H Yes, specify Cuba		pecify Yes or No- o Rican, etc.)		. Race - Americ Black, White,	
0036	ural", or	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐Yes 2☑No	Specify:			pecify: W	Thite
	itnin 72 r ne. nan "nat	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give I life. E	ent's Usual Occup- kind of work done of NOT use retired	luring most of worl)				
d 21	riled within Hygiene. other than " ent, it in	Be Col	11 17. Father's Name (First, Middle, Last)		Cred	it Colle		ne (First, Middle, I			Clothing
Maryland	snould be ind Mental s marked o umatic eve	To B	Howard Jeffe	erson White, Si				a Theres			
Mar	har har 7 is trau		19a. Informant's Name/Relationship (Grace V. White	Type. Print) Wife		g Address <i>(Street .</i> Piper Roa		iral Route Numbel istersto		own, State, Zip Maryla	
	es 1 and 2 of Health fitem 27 i	- 37	20a. Method of Disposition	20b. P		sition (Name of natory or other place				ation - City or To	
	rages ment of l tant: If its jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Saint	s Cemete	ry 8/6			stersto	
Balt	permit. Pages Department of Important: If it any injury or once.	1 (2	21. Sign rur of Funeral/Service Licer	M. Jenk		Name and Address INE FUNE		824 Reis Reiste			ad 21136
P	hysician	8 16	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line.			g, such as cardiad		rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence)							
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence)	uence of):						
68760,	Attending Fripsician: The law requires that the beath certificate be executed rideal. ctor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	that initiated events resulting in death) Last	CDue to (or as a consequent	uence of):						
x 68	ding ph	/Medi	IF FEMALE:	220 If you outcome of progns	nnov.					N. D. L. of delle	
O. Box	at the death certification is as tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	Ideath 3	Ectopic pregnanc Other (specify)	у		23	Month	Day Year
rds, P.	luires man n signed b	ğ	Part II. Other significant conditions of CHNONIC OBST	contributing to death but not resin	ulting in the ur	nderlying cause giv	en in Part I.				the cause of death?
of Vital Records,	cate has been s page 2 should	Completed	CLOSTRIDIUM	DIFFICILE	COLi	Tis		24a. Was a autop: perfor		24b. Were autoprior to codeath? 1 □Yes	opsy findings available ompletion of cause of
ital	sician: ine certificate l irector, page	Be C	25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes ath (Check only or		I Li Yes	2 LADNO
of V	rnysic this ce al direc	ျ	1 ☐ Yes 2 ██No	Hospital:			4 🗆 Nursing F	lome 5 Resid			ify)
on o	After funera	tion:	27. Manner of Death ↑ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	yat <br Yes 2 □No	28d. Describe h	now injury	occurred	
5	after death. Director A In by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, stro jy)	eet, factory, office		28f. Location (S City or Tow		Number or Rui	al Route Number,
	Tospita 4 hours Funeral tely filler	Medical C	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, deati	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
, i	vithin 2 To the I	Me	29b. Signature and title of certifier	e on	>	29c. Licens	e number んろこと	i		signed (Month	
			30. Name and address of person who	completed cause of death (Iter	n 23a) (Tyne					J	
			NORTHWEST HO	completed dadde of death (not	1 Lou) (1)po,	11111) 1-11 620					

DHMH 17 Rev 1/2001

10-05455 Ulrice Wair

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # State of Waryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day 1630 hrs Adical Examiner Ulric Wair 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 9. Birthplace (State or ForeignSt. Louis 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5 Social Security Number Funeral Months Min Days Hours Director Country) MO 1X M 2 F Yrs July 19 498-44-1048 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No 28a-f show 'natural", or items 23a or 28a-f shov Examiner must be notified at once. Maryland Charles Waldorf Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20601 United States 2460 Shawnee Lane Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married 1 X Yes 2 "natural", or within 72 hours after 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77. Department of Health and Mental Hygiene. Important: If item 27 is marked other than Federal Government Public Affairs Specialist 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be traumatic event, Richard A. Wair Jessie Mae Lyles ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2460 Shawnee Lane Waldorf, Maryland 20601 Diane Wair / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 7/30/2010 Cheltenham, Maryland 4 Donation 5 Other Specify: Marvland Veterans 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part I. Enter the disease failure. List on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. /Medical Death a Blunt Force Head Trauma Immediate Cause (Final dis Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical attending physician a or use as the burial -UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) ō Yes 2 No 9 Unknown g Unknown the ached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ signed b Ď 1 Yes 2 V No 3 Probably 4 Unknown Completed s peen s 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has death? performed? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes No 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury After Certification: Jul 21, 2010 Driver auto fixed object collision Natural 1622 hrs 1 Yes 2 ✔ No Director: Pending hours after death. 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) S/B I495 at St. Bernabas Road, Oxon Hill, MD within 24 hours at To the Funeral L (Specify) Interstate/Express To the Hospital Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registra

AUG 0 9 2010

OCME

32. Registrar's Signature

William Shane Webskir Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-05266

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 14, 2010 0011 hrs **Medical Examiner** William Shane Webster 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 610 Americana Drive Annapolis If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign U Min Months Davs Hours Director 37 Oct 17, 1972 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State any MD Anne Arundel Annapolis 1 Yes 2 X No s 23a or 28a-f show e notified at once. or 28a-f show with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 97 Monticello Avenue 21401 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Armed Forces? UNK 11. Marital Status unk 14. Race - American Indian, Black, White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 No Yes Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after de
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or i
ning yor other trammatic event, the Medical Examiner mu Specify: White If Yes, Give Year or Dates: 1 Yes 2 X No specify: 3 Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done UNK 16b. Kind of Business/Industry UNK 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 17, Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) UNK Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ Michale Connolly - stepfather 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in state 21. Signatur of Funeral Strvice Licenses 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 Approximate Interval art I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and ire. List only one cause on each line. Death Alcohol, cocaine and morphine intoxication Immediat Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi The law requires that the death certificate be executed sician/Medical XUNPENDED AMENDED 27,28a-f,per ME g906 8/18/10 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year 1 Live birth Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phys Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 V Unknown Completed is been si should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? 1 🗸 Yes Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 1 Yes 2 No 5 Pending 7/14/10 FD 12:05 am Fd 2 Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State 10 Americana Dr Annapolis, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be house determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 14, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Registrar

AUG 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year U Physician/ 10:10 AM Edmund Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Good Samaritan Hospited 5. Social Security NumberUnk | 6. Sex If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 X M 2 □ F Hours Octonin Day, 19940 Il Trois 69 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Towson 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 USA 509 East Joppa Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces?

1 A Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Ş 1 Never Married 2 Married Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) VP of advertising market research Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 William Young Elizabeth Carrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Brandt - friend 806 Mockingbird Lane; Towson, MD 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Stopper (Specify) in state 22. Name and Address of Facility State Anatomy Board Ronald So Wade 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Physician/ disease or condition Medical resulting in death) Examiner DECOBITUS ULCER LA93BZ INFECTED Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Live Fetal Good 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) oleted by

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director,

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9 Unknown	g 🗌 Unknown		
•	is contributing to death but not resulting in the underlying cause given in		cco use contribute to the cause of death?
		24a. Was an autopsy performe 1 ☐ Yes 2√	
5. Was case referred to medical	26. Place of	Death (Check only one)	

E 05			performed? death? 1 Yes 2 No 1 Yes 2 No
lo Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check on Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	nly one) 2 5 ☐ Residence 6 ☐ Other (Specify)
ricate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
E	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)

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29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur of the basis of examination and/or investigation of the basis of examination and or investigation of the basis of examination of the basis of examination of the basis of examination of the basis of	on, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and manner stated				
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
M.D	UMPS 23986	08/01/2010				

MI.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Blvd. Baltimore 21239, M.D. Mohan Ruellappa 5601 Lochlaven

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY CHARLES WOOLVERTON ATLEE, JR. 20ÎO 12:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES CHARLES COUNTY NURSING & REHABILITATION CENTER LA PLATA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours AUGUST 25 Year 1914 MARYLAND Director 220-05-4256 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location Director MARYLAND CHARLES INDIAN HEAD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's UNITED STATES ō iral", or items 23a or Examiner must be Funeral 20640 6230 GREENWAY DRIVE death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. Specify: BLACK red v... al Hygiene. ad other than "natural" → the Medical E "natural" Completed 3 Widowed 4 Divorced 1945 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7TH GRADE College (1-4 or 5+) FEDERAL GOVERNMENT **FOREMAN** Be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If item 27 is marked o CHARLES WOOLVERTON ATLEE, SR. MABLE A. BUTTS ATLEE traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 6230 GREENWAY DRIVE, INDIAN HEAD, MARYLAND DOROTHY E. ATLEE / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MARYLAND VEITERANS CEMETERY JULY 30, 2010 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) ure of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN THORNTON JOHNSON MO0583 HEAD MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betwee shock, or heart failure. List only one cause on each line. ediate Cause (Final ase or condition Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Seame stintly list our afficient Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ģ Month Year Pregnant at time of death signed by the a 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 X No certificate ₁ ☐ Yes 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify, Hospital 2 **X** No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury 5 Pending s after death.

I Director: Af
d in by the fu 2 🗆 No М ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JULY 23, 2010 of person who completed cause of death (Item 23a) (Type, Print) SUITE 207 12070 OLD LINE CENTRE, 30. Name an WALDORF, MARYLAND 31. Date filed (Month State istrar's

Registrar

		For State	State	of Maryland	-			nd Menta		00	ın	21.011
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Is	ast birthday)	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Da Min. (M	te of Birth on th, Day, Y	(ear)	9. Birthp	place (State or Foreign
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and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation					1	0d. Inside City Limits
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rylan nould be d Mental marked c	င	Willie Frede		dolphsen			Ketu		Grace	Kep		Code)
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Baltimore, Maryland 21215-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Eventinar must be nutified at once.	ľ	21. Signature of Funeral Service		+ 1110		Name and Addr						
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		23a. Part 1 Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death each line.	. Do not ente	er the mode of dy	ing, such as c	ardiac or resp	iratory arres	it,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Con	gestive	Heart	Failure						Onset and Death 2 months
/Medical Examiner		resulting in death)		(or as a consequ	·				-			
	<u>~</u>	Securifiedly list conditions if any, leading to immediate b. Ruptured Mitral Valve (Chordae Tendinae) Due to (or as a consequence of):										
uted J ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		ertensio								
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ath cer attendir or use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnar birth 2 Fetal	death 3	Ectopic pregnan	су				ite of deliver	rery Day Year
he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pre	gnant at time of de nown	eath 5∟	Other (specify)						•
that the the detac		Part II. Other significant condition	ns contributing to	death but not resu	Iting in the ur	nderlying cause gi	ven in Part I.	2:	3e. Did toba	cco use conf	tribute to t	the cause of death?
law requires t as been signe 2 should be c	d by	Peripheral Ar	terial D	isease					1 ☐ Yes	2 □ No	3□ Pro	bably 4 ☐ Unknown
w rec	Completed	Chronic Arter	ial Fibr	illation				24	4a. Was an	24b.	Were auto	opsy findings available
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OI V Physic r this ce	2	examiner? 1 ☐ Yes 2 🔯 No	Hospital: 1 □	Inpatient 2 🗆 I	ER/Outpatien	t 3 DOA Ot	her: 4 🗆 Nurs	sing Home 5	Residen	ce 6 □Oth	ner (Speci	fy)
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or All	Ħ.	4 ☐ Homicide determ	ned 28e. Plac build	e of Injury - At hor ding, etc. (Specify	me, tarm, stre	еет, тастогу, опісе		281. LO	ty or Town,	et and Numi State)	oer or Hur	al Route Number,
		29a. Certifier 1 ☑ Certifyin	g Physician: To th	ne best of my know	wledge, death	occurred at the	time, date and	d place, and du	ue to the car	use(s) and m	anner as	stated.
he Ho: ne Fur netely	Medical		Examiner: On the									
To th Within To th	Me	29b. Signature and title of certifier	, ,	, ,		29c. Licen	se number		290	d. Date signe	ed (Month,	Day, Year)
		· En	M	lu-		D25	947			Ju.	ly 26	5, 2010
104		30. Name and address of person						_				
		Evelyn D. Jack		. 3416 O Registrar's Signat		od Ct, S	uite 2	00 Ol	ney, M	Marylar	nd 20	832
Stat	ė	31. Date filed (Month, Day, Year)	วกาก 🏻 🏂	registrar s bighat	To ha	· N. I						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William C. Anderson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital Lanham . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplace (State or Foreign Funeral If Under 24 Hrs. 8. Date of Birth 1 X M 2 □ F 577-52-8899 Hours (Month, Day, Ye Washington. Director 71 ່ ໃ938 Usual Residence of Decedent 23a or 28a-f shov ast be notified at 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Maryland Prince George's Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a Examiner must b 9315 Wellington Street 20706 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or b Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Year or Dates White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working liste. DO NOT use retired)
Distribution Warehouse Center Manager Elementary/Seconday (0-12) College (1-4 or 5+) Toys R Us Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Hugo Anderson Mary Sue Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ruth Anderson/ Wife 9315 Wellington Street Seabrook, MD 20706 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 7/21/2010 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a con lequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last Jo the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant Month Day Year Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ob requestive 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 1 Within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pendina Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, 30. Name and address of who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}20<u>10</u> Physician/ July 12:01PM Benjamin Alston 21, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince Georges Southern Maryland Hospital Center Social Security Number (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days (Month, Day, 101) 54 Hours 1 X M 2 🗆 F **Director** 225-90-0536 Pennsylvania Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matified at 10a State 10c. City. Town or Location Director 1 ☐ Yes 2 X No Clinton MD Prince Georges 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20735 USA 6716 Berkshire Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Was Deceuent Armed Forces?

1. Yes 2 No. 74 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Black Year or Dates. 2001 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Acquisitions Human Resources Contract Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Robert Lee Alston Susie Anna Faulcon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Alston, Jr. 2658 N. Armistead Ave. #X4, Hampton, VA 23666 - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampton Memorial Gardens 17/30/2010 Donation 5 Other (Specify) Hampton, VA 22. Name and Address of Facility Signate of Fuheral Service Licens Nickelson-Cummings Funeral Home 4304 Victoria Blvd, Hampton, VA 23669 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Ecquentially list conditions. Examine to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Month Pregnant at time of death 5 Other (specify) Yes be detached a I Inknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 2 performed? 1 Yes Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 2 ည 1 🔲 Yes ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 5 \square Pending Natural 2 🗌 No Accident Investigation hin 24 hours after death the Funeral Director: / the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one) within To the Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19^{Day} 2010 ear Physician/ July 4:14 A M Adams Barbara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly 6. Sex 7. Age (In yrs. last birthdav) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🖾 F Days Min. June 21 Year 1936 74 South Carolina 577-50-1646 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20019 United States 5128 H Street SE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Investigator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence V. Johnson George H. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Riakos L. Adams/ Son 5128 H Street SE Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Harmony 1 A Burial 2 Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Landover, Maryland Memoria. 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Deter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock anheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fatal Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 ☐ Yes 2 🔀 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 X No Other: ျ 1 Tes 1 Inpatient 2 IN ER/Outpatient 3 IN DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) weller VEENA MYSORE, M.D. á

State Registrar Veena_S.

31. Date filed (Month, Day, Year)

27

32. Registrar's Signature

5100 Auth Way Suitland, Maryland

20746

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Mysore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Year Edward Allen Bowers 8:48 P M July 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll **Examiner** Carroll Hospital Center Westminster . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1**X** M 2 □ F 62 Mary Land Director 212-48-8759 May 8. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2 🔀 No Westminster Maryland Carroll 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 2220 Old Washington Rd. 21157 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 1967If Yes, Give 1969 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian Examiner Black, White, etc. 1 Never Married 2 Married Completed by 'natural", or 72 hours after 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Worker 1 and 2 should be filed witi f Health and Mental Hygier item 27 is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard Bowers, Sr. Viola Wilhelm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2220 Old Washington Rd., Westminster, MD 21157 JoAnn Bowers/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 TBurial 2 Cremation 3 Removal from State 07/26/2010 Eldersburg, Maryland 4 Donation 5 Other (Specify) Memorial Park 21, Signature of Funeral Service Licenses 22 Protets Fundamental Home and Chapel, P.A. rec 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 ☐ No 25. Was case referred to medical examine?

1 Pyes 2 No 26. Place of Death (Check only one) æ Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ᅆ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

MSL GTNA

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A- GIANCERUSO

MA

200

2 Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MEMORIAL AVE.

WESTMINSTER.

10-05396 Thomas Blue Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oma	s Blue		State of Maryland /					Menta	al Hy	giene		21	0 1	0	21.01
			1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Cer	Certificate of Death						Reg. No. 2 0			-	2481
edic	Physicia al Exami		Thomas Joseph Blue Month Day Year July 19, 2010												of Death 6 hrs
7			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death									4c. County o	f Death		
			Rt 15 and Old Frederick Road			Frederi	ck					Frederick	(
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. Ia	ast birthday)	If Under		If Under			•	M/DD/YYYY)			State or
	Director		212-76-1818 ₁ X _M ₂ F	52	Yrs.	Months	Days	Hours	Min.	Feb.	27,	1958	Foreig Pe III		vania
			Usual Residence of Decedent			<u> </u>									
	w an)		10a. State 10b. County 1	0c. City,	Town or Location	on							Ì		side City Limits
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	ith the		42 Frederick Street 21793 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S						2/6	aif . Van a		ted S			- Dissi
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	iter de		3 Widowed 4 XDivorced If Yes, Give Year	_ No	1	Yes 2X	No	specify:				Specify:	W	nite	
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21215-0036	denta Menta narke event	o Be	Thomas E. Blue 19a. Informant's Name/Relationship (Type, Print)	_	19b. Mailing	Address	/Street a	and Numbe					State	Zin Cod	۵۱
MD	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Thomas E. Blue / Father		5303 Q										
e,	Health item		20a. Method of Disposition		Place of Disposit		of ceme	tery,		Date	200	. Location -	City or	Town, St	ate
Baltimore,	ages ant of at: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	7	rematory or othe auffer		tor	_y 7	//22	/2010	$ \mathbf{F}_{\mathbf{r}} $	ederi	ck,	Mar	y1and
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	uted nd ransit	events resulting in death) Last Due to (or as a consequence or): d.													
Ğ	e be executed sician and burial - transit	dical	UNPENDED AMENDED												
	death certificate te attending phys for use as the b	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome 1	of pregn		al ala atta	2	Ectopic pi	rognone		2	3d. Date of c		0	Year
Box 6876	h certi endin use as	cia	past 12 months?	ne of dea	- H	il death er (S <i>pecif</i> y	<i>)</i>	Ectobic bi	regrianc	. у		MOUTH	D	ay	real
Bo	e deat the at ed for	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown												
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy: completely filled in by the funeral director, page 2 should be detached for use as the b	ģ	Part II. Other significant conditions contributing to death to Cirrhosis	out not re	sulting in the un	derlying ca	ause give	en in Part I	I.			o use contrib ✓ No 3		_	
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R	cian: The law certificate has ector, page 2 sl	ပိ	25. Was case referred to medical			26.	Place of	Death (Cl	heck on	1 ✓ Ye	s Z	No 1	Yes		2 No
Vita	hysician: The la this certificate ha I director, page 2	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2	ER/Outpatient		-04				Resid	dence 6 🗸	Other:	Scene	
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i≥i	Hospital or Attene 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be 28e. Place of Injur			, factory, of	ffice buil	ding, etc.				and Number			Number, City
	ospita hours ineral y fille		4 Homicide determined (Specify) Loca		-										erick, MD
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Check only one) 2 Medical Examiner: On the basis of examiner:	_				-)
	To To	Mec	29b Signature and title of certifier	7	71001	29c, L	icense n	umber			29d	. Date signed	(Mon	th, Day,\	'ear)
			3/10/1	1/01/	11/1086		D.C.M.	E.			Ju	ly 20, 201	0		
			30. Name and address of person who completed cause of dea	ath (Item 2	23a)										
10			Victor Weedn MD JD Assistant Medical E	xamin	er 111 Pe	nn Stre	et, Bal	timore,	MD 2	1201					
		ate	31. Date filed (Month, Day, Year) 32. Registrar's		e Ass	Red									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-i per me,2906,08/27/2010dhb

Certificate of Death

Reg. No. 1 - State Registral 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7 Charles F Bantz 27 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ST Masy's Charlotte Hall Veturns Home charlotte Hall If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F 83 Director March 25,1927 Maryland 579-32-3328 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Exposition count be notified at 1 □Yes 2 No Director Maryland St. Mary's Mechanicsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a 41920 Gibson Drive 20659 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1945-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: White ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farming 10 Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be Marian Ursula Rollins Charles Frederick Bartz, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 41920 Gibson Drive, Mechanicsville, MD 20659 Marie Burroughs/Sister permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Trinity Mem. Gardens | 07/31/2010 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ED BY MEDICAL EXAMINER Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Exami Heart attending physician a for use as the burial Box 68760, dailine Physician/Medical IF FEMALE: NA 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No signed by the a Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Intestinal Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 ☐No NA 1 □Yes 2 ☑No Division of Vital 25. Was case referred to medical examiner?
1 ★ Yes 2 ★ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred Subject flipped back out of wheel chair. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t or Attending 5 Pending investigation Natural 5:30 p. M 01/21/2010 1 ☐ Yes 2 X No 2 X Accident neral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Flural Route Number, City or Town, State) 29449 Charlotte 4 \ Homicide Hall Rd., Charlotte Hall, MD Nursing Home To the Hospital within 24 hours a To the Funeral D Hospital 1 E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD Thisin 05 7/29/2010 00064324

DHMH 17 Rev 1/2001

State Registrar

.3

Rd, Paince Frederick, MD, 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1100 Huspital

gistrar's Signature

Santha

31. Date filed (Month, Sin)

		1	For State Registrar	ate of Maryl		rtment of He rificate of De			2010	24818	
Phys	sicia		Decedent's Name (First, Middle, Last)	Shall				2. Date of Death Month		3. Time of Death	
M	ledica amine	al -	la. Facility Name (if not institution, give street	and number)	14 8	4b. City, Town, or Lo	ocation of Death	7	Day 2012 4c. County of Dea		
A LAC		4420 Owensville Sudley Rd.				Harwood			Anne Aru		
Fund Direct			5. Social Security Number 6. Sex 1 \square M :	7. Age (In y)	rs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth 4/27/196.	ar) Uni	thplace (State or Foreign buntry) ted Kingdom	
pu mou	te	. t	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation				10d. Inside City Limits	
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ith the 33a or 3	t be no	Funeral Director	Oe. Street and Number 4420 Owensville Sudl	ev Rd		10f. Zip Code 20776			Citizen of What Co		
IOTCE, MISTYISHIG 21213-UU30 ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show	er mus	Fune	11 Marital Status	as Decedent Ever in	10.S. 13. W	as Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spec	ify Yes or No-	14. Race - Ame	erican Indian,	
al", or	xamin	d b	0 □ Middewood 4 □ Discound	med Forces? Yes 2 X No Yes, Give ear or Dates.			Specify:	iodii, otoi,	Black, Whit	hite	
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Maryland 2 should be filed th and Mental Hy 27 is marked oth	umatic		Charles Joseph Cunni 19a. Informant's Name/Relationship (Type, Pr.		19b. Mailing				ty or Town, State, Z	ip Code)	
Te, Mi 1 and 2 st of Health a item 27 is	her tra	11/4	David N. Beavis/Husband 4420 Owensville Sudley Rd. Har							20776	
TOFF	y or of		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	b. Place of Dispos cemetery, crem Kalas Cre	atory or other place)	7/21/		c. Location - City of		
baltimore, permit. Page 1 and Department of Hee Important If item	ny injur	1	21. Signat u. 7 f Funeral Service License		22.	Name and Address	of FacilityGeor	ge P. Ka	las Funer	al Home	
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Priysic			shock, or heart failure. List only one cau Immediate Cause (Final disease or condition	se on each line.	smach (9718				Interval Between Onset and Death	
Med Exami			resulting in death)	Due to (or as a cons	sequence of):	24/00					
		<u>i</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):						
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box death ce	d for us	Physician/M	in the past 12 months?	Live Birth 2 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year	
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uires tha	ad blu	ed by						1 🗆 Yes	2, Z No 3 🗆 1	Probably 4 🗌 Unknown	
law rec	e 2 sho	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of	
VITAI KECOIDS, ysician: The law requires is certificate has been sig	tor, pag	Be Col	25. Was case referred to medical			26. Plac	e of Death (Check	1 Yes 2		es 2 1 10	
r VIC Physici this cer	al direc	၉	examiner? 1 Yes 2, No Hospit 27. Manner of Death 28	1 Inpatient 2	2 ER/Outpatien		4 ☐ Nursing Hor		ce 6 Other (Spe	cify)	
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DIVISION OT tal or Attending PI is after death. al Director. After th	in by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - A building, etc. (Spe	At home, farm, stre	et, factory, office	2		ocation (Street and Number or Rural Route Number, City or Town, State)		
ospital hours	pd filled	Medical	29a. Certifier 1 Sertifying Physician:	To the best of my kr	nowledge, death o	ccured at the time, d	late and place, and	I due to the cause	(s) and manner as s	tated.	
DIVISION Of VITAI RECORDS, P.O. BOX 06/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	omplete	Mec	(Check 2 Medical Examiner: O only one) 3 Certifying Nurse Pra	the basis of examin ctioner: To the best of	of my knowledge, d	gation, in my opinion, eath occurred at the t 2gc. License n	ime, date and place	e, and due to the ca	blace, and due to the use(s) and manner a I. Date signed (Mon	s stated.	
\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ŭ			MI		230. 2.00113611	D0064	379	7/	2010	
ptr3			30. Name and address of person who comple	ted cause of death (her 91	No sestant	e Rd Si	pe300/	Anapolis a	D 21401	
Reç	Stat gistra		31. Date filed (Month, Day, Year) JUL 2 1 2010	32. Registrar's Si	ignature .	ales			ò		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 550 Youth Year 2010 ARRY BURDICK FRANKLIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) D.C. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Davs Hours Min (Month, Day, April 10. 216-24-6329 83 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Definit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amortant: If item 27 is marked outher than "natural", or items 5a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🏿 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 331 Riverside Road 21037 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 1950-5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Specify: White 1950-51 Completed 3xx Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bernard Burdick Lillian Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fayann B. Rowe/Daughter 46 Ridge Avenue, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date July 26, 2010 1 🔀 Burial 2 🖵 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature Fineral de vice Licens 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between O ____ nd Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my calcing death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title A certifie 29c. License number 21438

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of p

31. Date filed (Month, Day, Year) **JUL** 2 6 2010

445

EFENSE HIGHWA

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

le 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

David Burke		1- For State Registrar	SI	ate of iv	naryianu /	-	rtment of tificate of		and Men	tai Hygiene	Reg. No	201	0 24820
Physicia Medical Examir	ın/	1. Decedent's Nam								2. Date of De Month	eath Day		3. Time of Death 0109 hrs
Medical Examin	iei	Dav1d 4a. Facility Name (Steve				4	b. City, Town	n, or Location o	July 21,		4c. County of Dea	
		Fooks Road						Salisbur				Wicomico	
Funeral Director		5. Social Security N 215-62-2	2019	6. Sex			ast birthday) 6 Yrs.	If Under 1	Year If Under Days Hours			Fore	irthplace (State or ign ountry) MD
any		Usual Residence o 10a. State	f Decedent 10b. County			10c. City,	Town or Location	on					10d. Inside City Limits
land f show	ē	MD		comic	o	Sal	lisbury						1 Yes 2 X No
e Mary or 28a-	Director	10e. Street and Nu		1				10f. Zip Coo 218		,	-	itizen of What Co	untry?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		31996 Fo	oks ko	12. V	Vas Decedent I	ver in U.		s Decedent o	f Hispanic Orig	gin? (Specify Yes or N		14. Race - Ame	rican Indian, Black,
r death or iten	Funeral	1 Never Marri		117	rmed Forces? Yes 2	No				, Puerto Rican, etc.)		White, etc.	
ars afte	2	3 Widowed 15. Decedent's Ed							No specify: upation (Give I	kind of work done	16b.	Specify: Kind of Business	white
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-003 I within grene. ther th	omo	12 17. Father's Name	(First Middle	Last)			HVA	C Mech		's Name (First, Middle	i	eating a	nd Air
215 be filed ntal Hy rked of	Bec	William							Audre	ey Parks			
D 21 should and Me 7 is ma	의	19a. Informant's Na						Address (S		nber or Rural Route Nu Salisbur			
e, M I and 2 Health item 2	ł	Pamela (20a. Method of Dis	position		ife)		Place of Disposi	tion (Name o		Date		. Location - City o	
MOF Pages bent of ant: If		1 Burial 2 4 Donation 5			moval from Sta	٠-١	matory or oth		marva	07-23-201	0	Delmar,	Delaware
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If I tem 27 is marked other than injury or other traumatic event, the Medical	-	21. Signature of Fu	neral Service			•	22. N	ame and Add	ress of Facility uneral	Home 13		st Grove	
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uted id ansit	Medical Examiner	(Disease or hijury t events resulting in		c. Due to d.	(or as a consec	quence of):						
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transiti	dica	UNPENDED		AME	NDED								
8760 ifficate l		IF FEMALE: 23b. Was decedent		^	If yes, outcom	e of pregn		al death	3 Ectopic	: pregnancy	23	3d. Date of delive Month	Day Year
OX 6	Physician/I	past 12 months		4	Pregnant at t	me of dea	ath -	er (Specify)					-
P.O. Beres that the designed by the be detached f		Part II. Other signi		9	Unknown buting to death	but not re	sulting in the ur	nderlying cau	ise given in Pai	rt I. 23e. Did	tobacco	use contribute to	the cause of death?
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Vital ysician his cert directo	o Be	25. Was case reference examiner? 1 ✓ Yes	2 No	Hospita	1 Inpatien	t 2	ER/Outpatient		Other ₄	(Check only one) Nursing Home 5	Resid	ence 6 🗸 Othe	er: Scene
1 of Vital Records ling Physician: The law requi After this certificate has been i funeral director, page 2 should	<u>- t</u>	27. Manner of Deat	h	ا ا د	a. Date of Injur (Month, Day,Ye OUND:	/ ar)	28b. Time of In	jury 28c.	Injury at Work?	Subject sh			
Sior Attend r death ector: by the	ertification:	2 Accident		tigation J	ul 21, 2010		0005 hrs	factory offic	Yes 2	NO ,			ural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director:	ertif	3 ✓ Suicide 4 Homicide		not be	Specify) Roa		mo, ram, or oc	, 1000013, 5111	oo bananig, oto	or Town,	State)	Stone Road, Sa	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a. Certifier (Check only one) 2		niner: On the						ce, and due to the cau			
	ž	29b. Signature and	title of certifie						cense number			Date signed (Mo	onth, Day, Year)
11/14		30. Name and addre	ess of person	who comple	ted cause of de	ath (Itam '	23a)		.C.M.E.		Jul	y 21, 2010	
axen	1	Ana Rubio N	MD. Ass	istant Me	dical Exami	ner 1	111 Penn St		imore, MD	21201			
Sta Registr	ite rar	31. Date filed (Mont	UL 23	2010	32 Registrar	Signatur	g. Sar	Kar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JULY 2 0°10 12:15A M HARRY CORBIN, JR Medical 4b. City, Town, or Location of Death ROCKVILLE 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** SHADY GROVE HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 5100 Country) WV 1 M 2 □ F Days Hours 0394874920 90 204-05-3758 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits death with the Maryland **Funeral Director** MONTGOMERY POOLESVILLE 1 Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20837 15201 MONTEVIDEO ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent Ever Armed Forces? 1. X. Yes 2 \sum No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after the alth and Mental Hygiene. 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Maryland 212 College (1-4 or 5+) CARETAKER CEMETERY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unknown HARRY CORBIN, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2083719a. Informant's Name/Relationship (Type, Print) 15201 MONTEVIDEO RD., POOLESVILLE, VIVIANA WARREN/CARETAKER Health a more, 20a. Method of Disposition
1

Burial 2 Cremation 3

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot +arra STAUFFER CREMATORY 07/23/2010 FREDERICK, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Low see 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Preumonia Medical Due to (or as a consequence of) Examiner age (Chronic obstructive pulmonary Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury use as the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical respir that the death certificate be Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No þ Month Day Pregnant at time of death 5 Other (specify) detached g 🗌 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe o 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? 1 🔲 Yes 2 No မ 1 Minpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b, Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) @ dul D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Germantown. 19529 31. Date filed (Month, Day, . 32. Registrar's Signature State

Registrar

			FOI	partment of Health and I	Mental Hyg	giene		
				ertificate of Death		Reg. No. 20	0 24822	
	Physicia		1. Decedent's Name (First, Middle, Last) Donna L. Cameron		2. Date of Dea Month	th Day Yea 24 201		
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Ju <u>1</u> y	4c. County of D		
			23980 Rustic Way	Hollywood		St. M		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 M F 53 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birtl (Month, Day September	g. Year) 1956	Birthplace (State or Foreign Country) Florida	
			Usual Residence of Decedent		роросияст	23,2330	Tioriua	
	/land f sho ed at	ţċ	10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits	
	Man 28a- lotifie	ire	Maryland St. Mary's Hollyw				1 ☐ Yes 2 🖾 No	
	th the 3a or t be r	a D	10e. Street and Number	10f. Zip Code		10g. Citizen of What	Country?	
	ms 2 mus	Funeral Director	23980 Rustic Way 11. Marital Status 12. Was Decedent Ever in U.S. 13	20636	i6 . \/ N-	USA		
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fi	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🗓 No Specify:	Rican, etc.)	14. Hace - A Black, W Specify: Wh		
9	hours natura ical E	lete	15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Busine	es Industry	
215	n 72 9. nan "r Med	ğ		e kind of work done during most of work DO NOT use retired)	king	100110110 01 200110	as massay	
7	withi giene ygiene rer th		12 Mot	or Pool Driver		Transpor	tation	
nd	e filed ttal Hy ed ott	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam		Maiden Surname)		
<u>\Z</u>	uld be I Men narke	-	Richard C. Miller		a J Dye			
Maryland 21215-0036	2 sho th and 7 is r traun		1	ling Address (Street and Number or Rur				
رة آ	and Heali tem 2		William B. Cameron, Jr. / Husband 239 20a. Method of Disposition 20b. Place of Disp		Lywood,	20c. Location - City		
Baltimore,			1 😡 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, cr	ematory or other place)		•		
慧	permit. Page Department Important: II any injury or once.		[55, 55, 55]	22. Name and Address of Facility Mat	29, 2010 tingley-Ga	Hollywood		
ñ	any any		Kenn Al Philes			onardtown,		
п			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between	
- 1	Physiciani			tic Endometria	(Care	inoma	Onset and Death	
	Medical Examiner		resulting in death) Due to (or as a consequence of):				TO MICHAEL	
		ē	Sequentially list conditions, b.					
	ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury				U.	
	xecut n and al-trar	Exa	that initiated events c. Due to (or as a consequence of):					
09	death certificate be executed re attending physician and ed for use as the burial-transit	dical	d					
9/89	ifficate b ng phys as the l	Med	IF FEMALE:					
ý ×	tendir tendir or use	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3			23d. Date of		
		Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)		Month	Day Year	
O.	that the ned by t e detach	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
	juires en sigr uld be	ed k			1 □ Y	′es 2 □ No 3 □	Probably 4 Unknown	
Š	law requires nas been sig e 2 should b	Completed			24a. Was a		autopsy findings available to completion of cause of	
Ř	The la ate ha	Som			autop: perfor	med? death	Yes 2 No	
<u>o</u>	ctor,	Be (25. Was case referred to medical examiner?	26. Place of Death (Chec				
5	hysic this co al dire	ပ္	1 Spital: 1 Inpatient 2 ER/Outpati			ence 6 Other (Sp	pecify)	
0	Jing F h. After funera	Certificate:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury	work?	28d. Describe ho	ow injury occurred		
<u> </u>	deatl ctor: y the	tific	2 Accident Investigation 3 Suicide 6 Could not be		28f Location (St	reet and Number or	Rural Route Number	
Division of Vital Records,	al or A safter I Dire d in b		4 Homicide determined building, etc. (Specify)	,,		on (Street and Number or Rural Route Number, Town, State)		
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inversion only one) 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred a	t the time, date an	d place, and due to the	ne cause(s) and manner stated.	
	To th withir To th comp	2	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo		
			- CSUCha	D5068C		July 26'	n 2010	
3			30. Name and address of person who completed cause of death (Item 23a) (Type,					
JUY	Class		Gurdeep Chhabra 24035 Three Notch Rd 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	. Hollywood, MD 20	636			
	Stat Registra		31. Date filed (Month, Day, Year) JUL 2 0 2010 32. Registrar's Signature	bares				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ${\stackrel{\mathsf{Month}}{\mathrm{July}}}$ 20<u>10</u> 25 William Frederick Cherry 10:00 a.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 11/10/1938 Virginia Director 215-36-3154 71 Usual Residence of Decedent or 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16661 Three Notch Road 20680 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No "natural", Specify: 3 Widowed 4 Divorced Year or Dates White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bricklayer Construction Be It. Page 1 and 2 should be addressed of the street of Health and Mental Hy arthren of 1 s marked of the street of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Waverly Cherry Eva Woodall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15245 Point Lookout Road, St. Inigoes, MD Esther Cherry/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
First Friendship
Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify 07/29/2010 Ridge, Maryland Signa uneral Service
Edward N. F 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield 22955 Hollywood Road, Leonardtown, MD M00052 Jr. 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumomia lobour Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami evKomia attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No by the a 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaeco use contribute to the cause of death? signed Completed by To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2010 D0604

Registrar

Seme

State

Mehrdao

31. Date filed (Month, Day, Year)

Hospita

Leonar +

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

AKhlaghi

JUL 29 2010

Sti

Maryi)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 752 P M George Edward Catloth, Sr. 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Ye Dec 9 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Washington. Director 577-01-6211 91 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hydiene. Important: If tiene 27 is an anticed other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Prince George's Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3817 Winchester Lane 20715 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give 10/1/1/1/1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No Specify Specify: 3 Divorced 4 Divorced rear or Dates 1944-45 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of the Elementary/Seconday (0-12) College (1-4 or 5+) United States Army Technical Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Catloth, Jr. Mary Katherine Weidman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kate R. Catloth/ Wife 3817 Winchester Lane Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) fort Lincoln Cemetery 7/24/2010 Brentwood, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home Jer / Knig 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a co Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Ectopic pregnancy Month Dav Year Pregnant at time of death Other (specify) 4 ☐ Pregnant a g ☐ Unknown been signed by the should be detached g 🗌 Unknown Part II. Qther significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 25. Was dase referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Da State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24825 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 19^{Pay} 20°10 10:45 Godeva Cerrelli Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Prince George's Woodward Estates Bowie If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. (Month, Day, Year) **Director** 156-18-7302 86 New Jersey 18 Usual Residence of Decedent Show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director i X Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20716 USA 14997 Health Center Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Milton Latz Evalyn Loewy 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Ezio C. Cerrelli / Spouse 12419 Skylark Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State Beth Israel Cemetery 7/22/2010 Pleasantville, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licer 6512 NW Crain Hwy., Bowie, MD 23a. Part 1 Enter the disease, of shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final ONE AND DOOR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Dunito (or as a consequinter of, cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: ပု 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined

within 24 hours after deatl To the Funeral Director; the

> State Registrar

Medica

29a. Certifier

(Check only one

JUL 2 1 2010

of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 24826 State of Maryland / Department of Health and Mental Hygiene

Albert Anthony C			tate of Maryla				nd Menta	al Hygiene	5 E () 10 240L
Physicia		1- For State Registrar 28E, pe 1. Decedent's Name (First, Midd	er ME,QACHD,	7/23/1006		Dealims		2. Date of D	Reg. No.	3. Time of Death
Medical Exami		ALBERT ANTHO		.O, JR.				Month July 19,	Day Yea	
A. S.		4a. Facility Name (if not instituti		mber)		4b. City, Town, o		Death	4c. County of	
	Ц	154 Greenwood Cree				Queenstov		out. lo p	Queen A	
Funeral Director		5. Social Security Number		7. Age (In yrs.		If Under 1 Ye Months Da		Min.		9. Birthplace (State or Foreign Country)
Bireotor		212-82-5729 Usual Residence of Decedent	1 X M 2 F		46 Yr	S		DEC.	24, 1963	MARYLAND
any		10a. State 10b. County		10c. City	y, Town or Loca	tion				10d. Inside City Limits
ind show	7	MARYLAND QUE	EN ANNE'S		QU	EENSTOW	N			1 Yes 2 X No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Country?
h the 1		154 GREENWOOD				216			UNITED	
ith wit	Funeral	11. Marital Status 1 Never Married 2 X						n? (Specify Yes or I Puerto Rican, etc.)	No- 14. Race White	- American Indian, Black, e, etc.
ter dea			1 Yes	2 X No		Yes 2X N	o specify:		Specify:	WHITE
ours af	d by	15. Decedent's Education (Sp	or Dates:			nt's Usual Occup			16b, Kind of Bu	siness/Industry
6 72 ho	lete	Elementary/Secondary (0-12) College (1	-4 or 5+)		nost of working lif				M&M CONSTRUCTION
5-0036 led within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle	+ 4		MAR	RINE CON				
215- be filed ntal Hyg rked ott	Be C	ALBERT ANTHONY		CD				Name (First, Middle RRIS JACK)		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	lo B	19a. Informant's Name/Relation		DR.	19b. Mailin	g Address (Stre		er or Rural Route N		
imore, MD 21215-0036 Pages I and 2 should be fited within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		NANCY E. CANTE	LLO/WIFE							N, MD 21658
re, s l and of Heal of Heal		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal fr			sition (Name of co ther place) KE CREM		JULY 23,	20c. Location -	City or Town, State
imo Page ment c		4 Donation 5 Other S	Specify:		CE	INTER	ATTOM	2010		VILLE, MARYLAND
Baltimore, MD 2 pemit. Pages I and 2 shoul Department of Health and Iv Important: If item 27 is m		21. Signature of Funeral Service	Licensee	7.	^{22.} F (Name and Addres INERAL H	ss of Facility OME P	ELLOWS, 1	HELFENBEI SHAMROCK	N & NEWNAM ROAD, CHESTER
Physician		23a. Part I. Enter the disease, o	r complications that c	aused the deatl					TAKILANU	art Approximate Interval
/Medical		failure. List only one cause immediate Cause (Final disease	D							Between Onset and Death
aminer		or condition resulting in death)	Due to (or as a	consequence	of):					
	<u></u>	Sequentially list conditions,	b. Due to (or as a	consequence	of\:					
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itiated		consequence	01).					
ed	Examiner	events resulting in death) Last	Due to (or as a	consequence	of):					
iO, e be executed ysician and burial - transit	edical	UNPENDED	aAMENDED							
60, ate be e hysicia e buria	Medi	IF FEMALE:		outcome of pre	gnancy				23d. Date of	delivery
6876(certificate nding phy	ician/M	23b. Was decedent pregnant in past 12 months?	the 1 Live b	irth	2 🗌 F	etal death 3	Ectopic	pregnancy	Month	Day Year
Box e death of the attented for us	/sici	1 Yes 2 No 9 Ur	nknown g Unkno	ant at time of d	eath 5 O	ther (Specify)				
	Physic	Part II. Other significant condi	tions contributing to	death but not	resulting in the	underlying cause	given in Part	11. 23e. Did	l tobacco use contri	ibute to the cause of death?
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	d by							1 🗆	res 2 ✔ No 3	Probably 4 Unknown
of Vital Records, by Physician: The law requir witer this certificate has been somether director, page 2 should	Completed							24a. Wa		Were autopsy findings available prior to completion of cause of
(ecc	E O									death? ✓ Yes 2 No
ian: 1	BeC	25. Was case referred to medical examiner?				26.Plac	· · · · · · · · · · · · · · · · · · ·	Check only one)		
hysic aldire	To E	1 ✔ Yes 2 No		npatient 2	ER/Outpatien				Residence 6	
n of ding Ph	- El	27. Manner of Death 1 Natural 5 Per	28a. Date (Month FOUND	of Injury , Day,Year)	28b. Time of FOUND:	· · · _ ·	jury at Work? Yes 2 ✔ 1	Subject fo	e how injury occurr Il into water fro	
Division salor Attendi rs after death. al Director: /	icati	2 Accident Inve	estigation Jul 19, 2	2010	1016 hrs	et, factory, office			(Street and Number	er or Rural Route Number, City
Div	Certification:		ild not be	-⊙cean	Creek	, , ,	2-11-11-13	or Town	, State)	d, Queenstown, MD
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	alC	20a Cortifica	hysician; To the bes	st of my knowle	dge, death occu	rred at the time,	date and plac	e, and due to the ca	ause(s) and manner	as stated.
Co the comple	edical		aminer: On the basis of and manner s		and/or investiga	ation, in my opinio	on, death occi	urred at the time, da	te and place, and d	lue to the cause(s)
	ž	29b. Signature and title of certifi	er			,	nse number		-	ed (Month, Day, Year)
12		// / /		C. RIPP		n 0.0	.M.E.		July 20, 20	10
12/15		30. Name and address of perso Victor Weedn MD JD	n who completed caus Assistant Me			Penn Street,	Baltimore	. MD 21201		
	tate	31. Date filed (Month, Day, Year						,		
Regis		301	- 23 2010	Leneva	J. P. 1	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dollie Clifton 305 PM 2010 Medical 4a. Facility Namp (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🎛 F Months 218-34-7750 03/18/1923 Maryland 87 Director Usual Residence of Decedent or 28a-f shov 10a State 10c. City Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Wicomico Maryland Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30592 Zion Road 21804 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Midowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Anna Taylor Rouse C. Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30938 Morris Leonard Rd., Salisbury, MD 21804 Bonnie Smith/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Eastern Shore of MD
Veterans Cemetery 1 $\mbox{\em K}$ Burial 2 \square Cremation 3 \square Removal from State 7/26/2010 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Servi ²² Name and Address of Facility HOTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on eac used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ARDIO MYOPA THW disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the knoreal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 1 Yes ဍ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Dath Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d Describe how injury occurred work? 1 🗌 Yes 2 🗎 No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated tifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

21802

BUR

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 23

31. Date filed (Month,

Amended	ito	For State		State of M B.,7/26/10	aryland	d / Dep		Health and M	/lental Hygi	•	24828
Physici Medi	an/	1. Decedent's Nan	ne (First, Middle, La J. Dar	st)	,		_		2. Date of Death	Day Year	3. Time of Death
Exami			_	e street and number)	the	Lake		r Location of Death		4c. County of Dea	
Funera Director		5. Social Security N 212-28-	10 Number 6. S		e (In yrs. la: 79			If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Y Jan • 0	9. Bir Co	thplace (State or Foreign nuntry) PA
aryland a-f show fied at	ector	Usual Residence of 10a. State	10b. County Worce	ctor		Town or L	ocation Pines				10d. Inside City Limits 1 ☐ Yes 2 😾 No
vith the Ma 23a or 28 st be notii	Funeral Director	10e. Street and Nu			_ 00,	ean i	10f. Zip Code 218	 811	10	g. Citizen of What Co	L
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status	ried 2 🗌 Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
215-0 in 72 hour e. nan "natu	Completed	(Sp Elementary/Sec 12	15. Decedent's lecify only highest grounday (0-12)	rade completed) College (1-4 or s	5+)	(Give life. l	DO NOT use retired,	during most of work	ing	6b. Kind of Business	·
Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	To Be Co	17. Father's Name	(First, Middle, Last)			Bro	ker		e (First, Middle, Ma M. Fore	,	te
Maryl d 2 should I alth and Me		19a. Informant's N	lame/Relationship (Type, Print)	ghte:	ı	= '	and Number or Run	al Route Number, C	ity or Town, State, Zi	p Code) MD 21811
Baltimore, N permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other 1 once.		20a. Method of Dis	position	Removal from State	20b. Pl	ace of Disp emetery, cre e Hel	position (Name of ematory or other pla nlopen (ce) Crem.7-2	Date 6-10 F	oc. Location - City or rankford	Town, State DE
Balt permit Depart Impor any inj		1	uneral Service Light	achila		<u>h</u>	08 Willi	am Stre	et Berl	uneral H in, MD 2	
Pnysician Medica Examine		23a. Part 1 Enter shock, or he Immediate Cause disease or conditi resulting in death)	art failure. List only (Final on	nplications that cause one cause on each lin a. Due to (or as	e. IG-NA	NT		ng, such as cardiac			Approximate Interval Between Onset and Death
60 te be executed ysician and ne burial-transit	dical Examiner	Sequentially list cause. Enter Und. Cause (Disease o that initiated even resulting in death)	ts 🔳	b. Due to (or as	·						
ords, P.O. Box 68760 requires that the death certificate been signed by the attending physishould be detached for use as the steel	by Physician/Medio	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknow	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	death 3	☐ Ectopic pregnan	су		23d. Date of de Month	elivery Day Year
cords, P.O. law requires that the nas been signed by the 2 should be detach	ed by Pł	Part II. Other sign	ificant conditions	contributing to death t	out not resu	ulting in the	underlying cause g	iven in Part I.	23e. Did toba		o the cause of death? Probably 4 Unknown
Record The law requate has bee page 2 shol	Completed								24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
Vital ysician: is certific director,	To Be	25. Was case referexaminer? 1 Yes 2	0	Hospital:	ient 2 🗆 i	ER/Outpatio	26. Pent 3 DOA Oth	elace of Death (Chec ner: 4 Nursing He		ce 6 Other (Spec	city) HOSPICA
Division of Vital Records, To the hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director After this certificate has been signompleted filled in by the funeral director, page 2 should b	Certificate:	27. Manner of Dea Natural 2 Accident 3 Suicide 4 Homicide	5 ☐ Pending Investigation 6 ☐ Could not	be 290 Place of Ini	y, Year) ury - At hor		wor		28d. Describe how	injury occurred et and Number or Ru	200
Div Hospital or 24 hours afte Funeral Dir leted filled in	Medical C	(Check	🖆 🔛 Medical Exan	ysician: To the best of niner: On the basis of e rse Practioner: To the	examination	and/or inve	estigation, in my opin	ion, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated
To the within 2 To the comple	Σ	29b. Signature and		337 Factioner: To the	Dest of filly	Mowieage	29c. Licens	se number	29	d. Date signed (Mont	
BA 6		6 Hus	My W	completed cause of o	death (Item	23a) (Type,	Print) 173	00584 Ski	is sign	y wo	21802
Sta Regist		31. Date filed (Mor.		32. Registr	ar's Signati	ure	6.41			/	

		For State Registrar	State of Maryla	and / Depa <i>Cer</i>	artment of H <i>tificate of L</i>	Health and N De <i>ath</i>		giene201(24829
Physici	on/	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
Medi	cal	David Allan	Dixo	n			Month July	23, 2010	
Exami	ner	4a. Facility Name (if not institution, give str 22909 Cedar Land				r Location of Death Leonardto	V-772	4c. County of De	
Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h g F	Birthplace (State or Foreign
Director		212-92-1130	M 2 □ F 50	Yrs.	Months Days	Hours Min.	July 12	, Year 1960 N	ountry) lary1and
nd how at] -	Usual Residence of Decedent 10a, State 10b. County	10c.	City, Town or Loc	eation		1.50		10d. Inside City Limits
larylar 3a-f s	ect	Maryland St. Mary		eonardto					1 ☐ Yes 2 😾 No
the M	<u>=</u>	10e. Street and Number			10f. Zip Code			10g. Citizen of What	
h with ns 23a must l	Funeral Director	22909 Cedar Lane Ro			206			USA	
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	6	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates.		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	cation completed) College (1-4 or 5+)	(Give I	lent's Usual Occup kind of work done of D NOT use retired)	ation during most of worki	ing	16b. Kind of Busines	s Industry
d 21 ed with Hygier other t	BeC	17. Father's Name (First, Middle, Last)		Neve	r Worked				
Maryland 12 should be file 14 and Mental is 27 is marked or 17 traumatic eve	2	Robert Stephen D	Lxon			18. Mother's Name		,	
Aaryl should to and Me		19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street a			; City or Town, State, 2	Zip Code)
		Lydia Dixon / Sist	er	2290	9 Cedar 1	Lane Road	, Leona	rdtown, MD	20650
7 - 4 - 5		20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Re	emoval from State		natory or other plac	e)	Date	20c. Location - City	
Baltimo permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Specify)	Br					Charlotte H	
Derm Deperm Impo		21. Signature of Funeral Service Licensee		052 2	22955 Hol	lywood Rd	l., Leon	l Funeral H ardtown, N	-
		23a. Part 1, Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	- 0-		g, such as cardiac c	r respiratory arro	est,	Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)	Due to (or as a conse		ncer				Criset and Death
Examiner			End	Stage		r dis			
7 ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a conse	equence of):	p. L.	1.1-	s.5		
ecutec and -trans	Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a conse	equence of:	Kera	rdalio	7)		
foU cate be executed physician and s the burial-transit	edical	d d		ebo	al P	alsy			
5 / 60 ificate b ig physia as the b		IF FEMALE:			•		0		1
DIVISION OF VITAL RECORDS, F.O. BOX 08/17 to the Hospital or Attending Physician: The law requires that the death certification 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of preg 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 🗌	Ectopic pregnand Other (specify)	у		23d. Date of o	lelivery Day Year
uires that the signed by	by	Part II. Other significant conditions control	ibuting to death but not r	resulting in the u	nderlying cause giv	ren in Part I.			to the cause of death? Probably 4 Unknown
UNISION OT VIKAI HECOPIAS, ital or Attending Physician: The law requires rs after death. I Director: After this certificate has been signed in by the funeral director, page 2 should be and in the funeral director, page 2 should be a signed in the funeral director, page 2 should be a strong the funeral director.	Completed						24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
ician: Sertific ector,	Be	25. Was case referred to medical examiner?	spital:		26. Pla	ace of Death (Check		1	
Phys Phys	e: 10	27. Manper of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatien 28b. Time of	28c. Injury	4 U Nursing Ho		ence 6 Other (Spe	ecify)
on c arth. r: Afte	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work		2001130110	ow injury occurred	
JIVISION Attender of I Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (Si City or Town	treet and Number or Fi n, State)	ural Route Number,
le Hospit n 24 hour le Funera	Medical	(Check 2 Medical Examiner	an: To the best of my kno : On the basis of examinat Practioner: To the best of	ion and/or investi	gation, in my opinic	n, death occurred at	the time, date ar	nd place, and due to the	cause(s) and manner stated.
To th To th	-	29b. Signature and title of certifier		, , , , ,	29c. License	number	- 2	29d. Date signed (Mon	th, Day, Year)
			rah		\Box	4706	0	7.23	. 10
aw)		30. Name and address of person who com	,		,	T 000 1:	340	20650	
Sta Registr		Avani D. Shah, M.D 31. Date filed (Month, Day, Year) JUL 2'/ 2010	32. Registrar's Sign	nature		Leonardto	wn, MD	20650	
negisti	an .	JUL & I CUIL	1 Low	p. All	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AShiEH OGLAR ULBER 2140 M 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomsco *Salisbu* mingula Regional Medical 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months fonth, Day, 215-12-6520 Director Heual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amontant: In item 27 is marked of other than "natural", or items be notified at any Injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MANTECO 1 Yes 2 No (00); CO ARY AND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 21856 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) NoNE FARMER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SCAR ANNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ma 21801 ď 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 31-10 MANTICO soure of Funeral Service Li - UNERA Part 1. Enter the disease, or complications that cause death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 43CVI Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) examiner? 2 🖪 No |2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending hours after death, ineral Director; A 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier N# 164 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MB 21804 1415 3. DIVISION NATESA 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Amended item #8, WCHD, SLU, 7.2 Certificate of Death 10 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month ウブー Physician/ 2:40 P.M LOUIS **JAMES** DOYLE 22 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER 4 JUNIPER COURT OCEAN PINES If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 X M 2 □ F PENNSYLVANIA 90 Director 168-14-6196 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MARYLAND WORCESTER OCEAN PINES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 JUNIPER COURT 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ $\int Anle \le \cos \chi / \epsilon$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify If Yes, Give Year or Dates Specify: WHITE Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic execution. Elementary/Seconday (0-12) College (1-4 or 5+) CLAIMS OFFICER VETERANS ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KOPP **JOSEPH** DOYLE **GERTRUDE** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANGELINE J. DOYLE/WIFE JUNIPER COURT, OCEAN PINES, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State GATE OF HEAVEN CEM. 7/27/10 4 ☐ Donation 5 ☐ Other (Specify) DAGSBORO, DELAWARE Signuture uveral Se 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MYBLODYSPLASTIC SYNDROWIZ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transi Due to (or as a consequence of): ũ resulting in death) Last attending physician I for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? After this certificate has been signed by the atte funeral director, page 2 should be detached for a Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 → 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 2100 ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O 1300 Begistrar's Signature State JUL 2 R Registrar

			1 - For State Amended #12 Registrar	State of N per FH, R	Marylan G FCH	d / Depa D 7 /23 Cer	artmei /10 tificat	nt of H te <i>of D</i>	ealth eath	and N	/lental Hy	giene Reg. No2	010	24832
	Physicia		Decedent's Name (First, Middle, La	,	an ta	TIA TICITO					2. Date of De Month	ath Day 20,201	Year	3. Time of Death
	Medio Examir		R()NALD 4a. Facility Name (if not institution, giv FREDERICK MEMO)	VANCHO		, Town, or EDERI		of Death	JUL7	4c. Cou	inty of Death	
	Funeral Director		5. Social Security Number 173–36–8497		Age (In yrs. la	ast birthday) 2 Yrs.		r 1 Year		r 24 Hrs. Min.	8. Date of Bir Month, Pa Jan 31	th	9. Birth	place (State or Foreign ntry) sylvania
	rryland a-f show ied at	ctor	Usual Residence of Decedent 10a, State 10b, County Maryland Freder:	ick		y, Town or Loc				. =				10d. Inside City Limits 1X Yes 2 □ No
	/ith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 33 Concord Drive	<u> </u>			10f. Zi	p Code 21716	 5		I	10g. Citizen	of What Cou	
9800	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 X Yes 24 If Yes, Give Year or Dates.	?	If	Yes, spe	dent of His cify Cuban 2 1 No	i, Mexica	in, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, cify: wh	
21215-0036	Specify: Specif												f Business In	rnment
Maryland 2	Botom Services and Number or Rural Route Number, City or Town, State													
	id 2 shoul salth and I n 27 is ma er trauma		n, State, Zip and	^{Code)} 21716										
Baltimore,	Cemetery crematory or other place													
Balt	permit. Page Department of Important; If any injury or once.		21. Signature of Funeral Service Licer	al Ho										
=	Physician/		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each (ne.	xen			, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
فسيها	Medical Examiner	er	resulting in death) Sequentially list conditions,	b. ———	s a Jonsequ	rbiz	1	02	625	74				
	cate be executed physician and s the burial-transit	Examiner	day, bading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	s a conseque	s ver	.+;	12-	Hior	2				
3760	ficate be e g physicia as the buri	f edical		d										
. Box 687	The law requires that the death certificate be executed attends been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	n 2 □ Feta : at time of d	l death 3 🗌	Ectopic Other (s,		1				Date of deliv Month	very Day Year
ds, P.O.	requires that the been signed by should be deta	by	Part II. Other significant conditions of	contributing to death	but not resu	ulting in the ur	nderlying	cause give	en in Part	i L	23e. Did to	V		he cause of death?
Division of Vital Records,	The law recate has be page 2 sho	Completed									24a. Was auto perfo 1 Yes			psy findings available ompletion of cause of
/ital	/sician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	atient 2 🗆	ER/Outpatient	- 3 🗆 D	Other		'	only one)	donce 6 🗆 (Thor (Specif	
on of	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of in (Month, D	jury	28b. Time of injury		28c. Injury work?	at		28d. Describe h			<i>y</i>
28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route No. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route No. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route No. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route No. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route No. City or Town, State)														
	the Hosp thin 24 hou the Funer mpleted fil	Medical	only one) 3 Certifying Nur	iner: On the basis of	examination	and/or investi	gation, in eath occu	my opinior rred at the	n, death o time, date	occurred at	the time, date a	ind place, and e cause(s) and	due to the ca I manner as si	luse(s) and manner stated. tated.
	or wit		29b. Signature and title of certifier	Lee 1	Va	/	nd ,	nDD		06		29d. Date sig	ned (Month,	Day, Year)
5	A INA		30. Name and address of person who	completed cause of	death (Item	, , , , ,	rint)	Fr	ede	wie	k, mo	217	01	
Ĭ	Sta Registra		31. Date filed (Morith, Day, Year)		trar's Signat	ure	bar	Ke						

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	e Type or Pri					_		gible	•
		For State Registrar	State of M	aryland	•	artment of F <i>tificate of L</i>	tealth and N Death	•	giene Reg. No. 2 (010	24833
Division	,	Decedent's Name (First, Middle, La	ast)			tmodeo or E		2. Date of De	ath	.,	3. Time of Death
Physicia Medic	al	4a. Facility Name (if not institution, glv	MARY GAY	LE E	ATON	4h Cihi Taura	- Landing of Dooth	July		2010	5:05 A M
Examin	er	Citizens Care & 1		ion (Center		Location of Death			nty of Deat deric	
Funeral Director		5. Social Security Number 6. 220-42-7394	Sex 7. Ag 1 □ M 2 □ F	e (In yrs. Ia 66	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	th y, Year) 1943		thplace (State or Foreign untry) Texas
how at	۲	Usual Residence of Decedent 10a. State 10b. County	<u> </u>	10c. City	, Town or Lo	cation					10d. Inside City Limits
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ith the 23a or 3	Funeral Director	10e. Street and Number 1900 Rosemont Ave	enile			10f. Zip Code 21.7	n2		10g. Citizen o	of What Co	ountry?
eath w tems 2	Fune	11. Marital Status	12. Was Decedent I	ever in U.S	. 13. V		ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. R	lace - Ame	erican Indian,
after d al", or i xamin	<u>م</u>	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	No		Yes 2X No		Rican, etc.)	Spec	Black, White	e, etc. nite
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nd 2 sho ealth an n 27 is ier trau		Kerri A. Stevens					and Number or Rur n Muffin				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Ce	emetery, cren	sition (Name of natory or other plac uneral Ho	e) ome 7/24	Date / 2010	20c. Locatio		Town, State Maryland
ermit. P epartm nportal ny injul	Ì	21. Signature of Funeral Service Licer			z Rô	Name and Addres	SATLEY &	SON FUN	ERAL H	OMES,	P.A.
90 5 8 9	\dashv	23a. Part 1. Enter the disease, or cor	nplications that cause	the death	1.2	OI NORTH	MARKET S	TREET,	FREDER.	ICK,	MD 21701 Approximate
Physician/		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	. /	010.	nary K	letery	Dilen	11		Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):			,,,,,			
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certific anding puse as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnanc	v		23d. I	Date of de	livery
ne death / the atte ched for	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a			Other (specify)	7			Month	Day Year
is that the	হ	Part II. Other significant conditions	contributing to death b		ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Medical	(Check 2 \(\sum \) Medical Exam	ysician: To the best of niner: On the basis of earse Practioner: To the	xamination	and/or invest	igation, in my opinic	n, death occurred a	t the time, date a	ind place, and	due to the	cause(s) and manner stated.
Northi Com		29b. Signature and title of certifier	-//		Л	29c. License	number 6-128		29d. Date sigr	ned (Month	n, Day, Year)
		30. Name and address of person who Casper E. Cline	11/			rint)	t, Frede	rick. MI	21701		
State Registra	-	31. Date filed (Month, Day, Year)	32. Registra	s Signatu	ire .	pare	,				
negistra		JUL A	0 2410 P /Cd	island.	d fills	The second					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year RONALD 12:51 PM JAMES ELLIS JULY Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 609 OYSTER LANE OCEAN CITY WORCESTER 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 🔀 M 2 🗆 F SEPT. 2, 1933 MARYLAND 76 Director 220-28-1233 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND WORCESTER OCEAN CITY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 609 OYSTER LANE 21842 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) WATER SUPERINTENDENT LOCAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NORMAN LESTER ELLIS DOLLY ANN HICKMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shent of Health a tant: If item 27 is PATRICIA L. ELLIS/WIFE 609 OYSTER LANE, OCEAN CITY, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 7/26/10 DELMAR, DELAWARE 21. Signature of Funeral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Circhosis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No signed by the atte Month Year 4 ☐ Pregnant at time of death g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 🛎 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical To Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | 3 | (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifier 29d. Date signed (Month, Day, Year) 1766ets no 030619 26,2010 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 10445 Old Ocean City Blvd Suite! Beelin MD 21811 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Box 68760

P.0.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 0

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	Physicia			e (First, Middle, Last Cyrus Farza								2. Date of Dea July 22,		ďδ `	'ear	3. Time of 1:31	
4	Medic Examin			f not Institution, give s	street and numbe	r)		1	, Town, or Bethes	Location of			$\overline{}$	c. County of			
	Funeral		5. Social Security N 565-81-3	lumber 6. Se	r i	Age (In yrs. I	ast birthday) Yrs.		er 1 Year	If Under 24		8. Date of Birt (Month, Da March 9	th y, Year)			lace (State o	-
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	yland f shoved ed at	tor	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation							11	0d. Inside Ci	77.
	e Mar r 28a	Director	Maryland 10e. Street and Nur	Mon toome	ery	F	otomac	10f 7	ip Code		<u> </u>		10 0	Citizen of Wh	-t Caus		2 ▼ No
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	er mu	Funeral	11. Marital Status		12. Was Decede		S. 13.	Was Dece	dent of His	spanic Origin	n? (Speci	fy Yes or No-		14. Race -			_
21215-0036	e 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by F	1 ☐ Never Marr 3 ☐ Widowed	ried 2 🔀 Married 4 🗌 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Dates	★ No			ecify Cubar 2★ No	n, Mexican, I	Puerto Ri	can, etc.)		Black,	White, e		
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, Maryland	nd 2 shou saith and n 27 is m er traum		19a. Informant's Na Babak Far	ame/Relationship (Typerzami/Son	oe, Print)		1	0	,			Route Numbe ew York,			te, Zip C	Code)	
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth			position Cremation 3 Other (Specify		ate Nat	Place of Disponentery, cre Lional M	osition (Na matory or lemoria	me of other place 11 Par	e) S	July 201	^{te} 25,		Location - C 11s Chu	,		
Balti	permit. Page Department Important: I any injury o	Į į	21. Signature of Fu	uneral Service License	isle		2	2 Name 500 Ur	ng Addres nivers	oifins ity Blw	Fune d. W.	ral Home , Silve	e Ind r Spi	ring,MD	2090)1	
			23a. Part 1. Enter shock, or hea	the disease, or comp art failure. List only on	lications that cau le cause on each	sed the deat line.	h. Do not en	ter the mo	de of dying	g, such as ca	ardiac or I	respiratory an	rest,			Approximat Interval Bet Onset and	ween
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2	ed sit	miner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	erlying	Due to (or	as a conseq	uence of):										
2010	cate be executed physician and s the burial-transit	edical Examiner	that initiated event resulting in death)	ts Last	Due to (or	as a conseq	uence of):										
1 20 8760	tificate ng p hy as th	Med	IF FEMALE:														
July 22 133	Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent in the past 12 1 Yes 2 [9 Unknown	months?	23c. If yes, outcor 1 ☐ Live Bir 4 ☐ Pregnar 9 ☐ Unknow	th 2 🔲 Fetant at time of	al death 3	☐ Ectopic☐ Other (s		у				23d. Date Mont		-	Year
۳.O.A	s that the gned by se detac	by Ph		ficant conditions co		th but not res	sulting in the	underlying	ı cause giv	en in Part I.				use contrib			
rds,	w requires the special special bear the special specia	eted	- 9 - 2 - 3 - 2						~	-	_	-		2 [*] No 3			
Kourosh Vital Records,	The law rate has b	Completed by							, p.			24a. Was autor perfo	psv	pri	or to cor ath?	osy findings mpletion of o	available cause of
Xo C Vital I	sian: ertifica ctor, p	Be (25. Was case referr examiner?	<u> </u>						ace of Death	(Check o						
	Physic this ce al dire	욘	1 Yes 2	IA NO			ER/Outpatie			4 L Nurs		e 5 🗆 Resid)	
(m)	tending Fleath. or: After the funera	Certificate:	1 Natural 2 Accident 3 Suicide	fn 5 ☐ Pending Investigation 6 ☐ Could not be		Day, Year)	28b. Time o injury	М		rat ? Yes 2 🗆 N	No	3d. Describe h					
Fay 2ami	ital or At urs after o ral Direct lled in by		4 🗌 Homicide	determined	building,	etc. (Specif)	/)					3f. Location (S City or Tow	vn, Stat	te)			
12	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	only one)	Certifying Phys Medical Examir Certifying Nurs	ician: To the best ner: On the basis of e Practioner: To	t of my know of examinatio the best of m	ledge, death n and/or inve y knowledge,	occured a stigation, in death occ	at the time, n my opinio urred at the	date and plan, death occurrent time, date a	ace, and urred at thand place,	due to the ca ne time, date a and due to th	ause(s) a and plac ne cause	and manner ce, and due to e(s) and mann	as state the cau er as sta	d. use(s) and ma ated.	anner stated.
•	P Vith Co. P. Co		29b. Signature and	title of certifie	s.wi	ikc		29	c. License	number D63	195			ate signed (all 122)			
	7			ress of person who co Wilks, MD		of death (Iten	n 23a) (Type, Lown Roa	Print) d, Bel	hesda,	, MD 20	814						
	Sta Registra		31. Date filed (Mont	th, Day, Year)	32. Regi	istrar's Signa	ture	w.									

			For	St	tate c	of Maryla		artment of H			lental H	łygie	ne		
			1 - State Registrar				Cei	tificate of I	Deat	h			No.20	10	24836
	Physici	an	Decedent's Name (First, Middle								2. Date of Month		Day	Year	3. Time of Death
	/Medic	al	Doris Ma		ola			4b. City, Town, or	- I contin	n of Dooth	July	21	4c. County		7:45 A ^M
E.	Examin	er	4a. Facility Name (If not institution							ville					oru
	Funeral	-	Shady Grove Nur 5. Social Security Number	6. Sex		7. Age (In yrs	. last birthday)	If Under 1 Year	If Und	ler 24 Hrs.	8. Date of (Month,	Birth		ntgom 9. Birth	place (State or Foreign
	Director		577-46-5666	1 □ M	2 ∏ F	75	Yrs.	Months Days	Hours	s Min.	Nov 2	, 19	934	Wash	ington, DC
7	put "		Usual Residence of Decedent 10a. State 10b. County	,		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Aaryla F sho ed at	or		jomery				hersburg							1 □ Yes 2 ☐ X No
	death with the Maryland rms 23a or 28a-f show r must be notified at	Director	10e. Street and Number	JOHEL Y			Gaic	10f. Zip Code				10g.	Citizen of V	What Cou	ntry?
	3a or		902 Beacon Squ	are C	ourt	#103		2087	78			Ur	nited	Stat.	es
	death	Funeral	11. Marital Status	12. \		edent Ever in l	J.S. 13.	Was Decedent of H		Origin? (Specan, Puerto	ecity Yes or Rican, etc.)		14. Rac		can Indian,
õ	or ite		1 Never Married 2 Mar	ried 1	l ☐ Yes f Yes, Gi	2 X No ive	i	1 □ Yes 2 DXNo	Speci		, , , , , , , , , , , , ,		Specify		
5-0036	within 72 hours after ene. than "natural", or Ite he Medical Examine	d by	3 Novidowed 4 Divorced		ear or E	Dates:	160 Door	dent's Usual Occup	ation			164	o. Kind of B	4411	ite
7	in 72 "nat	Completed	15. Deceder (Specify only highe	st grade co	mpleted)		(Give	kind of work done of NOT use retired	during m	ost of work	ing	101	J. Killa of Di	u3111633/11	iddaliy
7 7	yiene. r thar the N	mo	Elementary/Secondary (0-12)	,	Jollege (1-4or 5+)	Sec	retary					Ar	t Ga	llery
ana	be filed within 72 hours after death with the Marylar tal Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle,	, Last)					18. Mo	ther's Name	e (First, Mid	dle, Mai	den Surnan	ne)	
Z	should be and Mental Ind Mental or marked or m	70	Paul Hershe			baugh				atie	Gert			eigle	
<u>a</u>	2 sh sand is m		19a. Informant's Name/Relations		,			ng Address (Street					-		
o,	1 and Health em 27 ther t		Carol Fogarty/ 20a. Method of Disposition	siste	T	20b.	Place of Dispo	20th Aven		•	Date	_	c. Location		
פַ	A - F		1 Burial 2 Cremation		val from	State	cemetery, cre-	natory or other plac		- 7/2	06/201			1	
Saltimor	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service			F II		rney Crem							
ñ	Dep Imp		Juanta Ox	2 Ono	mag	M009									e, MD 21029
Г			23a. Part1 Enter the disease, o shock or heart failure. Lis	r complication	ons that	caused the dea									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	tomy one of		atic Er	cephal	opathy							Onset and Death 1 month
	/Medical		resulting in death)	a		(or as a conse		эрашу							1 morrar
	Examiner	_	Sequentially list conditions,	b		rhosis (or as a conse		<u>r</u>							6 months
	ped issit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to	(or as a conse	equence or):								
	execu al-trai	Examiner	that initiated events resulting in death) Last	c	Due to	(or as a conse	equence of):								
8/60	cate be executed physician and the burial-transit	dical 8													
9	certificate be executed iding physician and use as the burial-transit	ledi													
gox	leath certifica attending ph I for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant			itcome pf pregi birth 2 ☐ Fe		Ectopic pregnancy	v					ate of deliv	
	e death the atten ned for u	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Preg 9□Unkr	nant at time of nown	death 5	Other (specify)					IVIC	onth	Day Year
7.	w requires that the de been signed by the s should be detached	Phy	Part II. Other significant conditi	ions contribu	uting to c	leath but not re	sulting in the u	nderlying cause giv	ven in Pa	nrt I.	23e. D	id tobac	co use con	tribute to	the cause of death?
ďŠ,	signe signe	l by	Hypertension		9 10 0		outing in the s								bably 4 ☑Unknown
cora	w requ been shoul	Completed									24a. W	/as an	24b.	Were au	opsy findings available
Ď		duc									a p	utopsy erforme	d?	death?	opsy findings available ompletion of cause of
VIII H			25. Was case referred to medica	al				-	26. Pl	ace of Deat	1 Ye		No	1 L Yes	2 No
5	Physician: this certific al director,	To Be	examiner? 1 ☐ Yes 2 XNo	Hosp	ital: 1 □	Inpatient 2[☐ ER/Outpatie	nt 3 DOA Oth			ome 5□F		e 6 □Otl	her (Spec	ify)
0	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 X Natural 5 ☐ Pendi		8a. Date (Mor	of Injury oth, Day Year)	28b. Time o	f 28c. Inju	ry at rk?		28d. Descri	be how	injury occur	rred	
IVISION	teath. tor: A the fu	catic	2 Accident invest	igation					Yes 2	□No					
Ĕ	or Atten	Certification:	4 Homicide determ	nined 2	8e. Place build	e of injury - At l ling, etc. <i>(Spe</i> c	home, farm, st c <i>ify)</i>	reet, factory, office			28f. Location City or	n (Stree Town, S	et and Numi State)	ber or Ru	ral Route Number,
_	pours a		29a, Certifier TV Certifyi	na Physicia	n: To th	e best of my kr	nowledge, deat	h occurred at the ti	me. date	and place.	and due to	the caus	se(s) and m	anner as	stated.
	To the Hos within 24 ho To the Fur completely	Medical	(Check only 2 Medical	l Examiner:	On the I	basis of examination	nation and/or ir	vestigation, in my	opinion,	death occu	rred at the ti	me, date	and place	, and due	to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certific	er				29c. Licens				29d	. Date signe	ed (Month	, Day, Year)
			Pris-					D2	36	056)	J	Tuly 2	1, 2	010
	5		30 Name and address of persor			,									
			Ravi Passi, M	I.D. 1	5245	Shady	Grove 1	Road, #13	0 F	Rockvi	lle,	Mary	land	2085	0
	Sta Registi		Ravi Passi, M 31. Date filed (Month, Day, Year	7 2010	32.	egistrar s Sigi	A. A.	arkel							
	negisti	e.i	002.0	- 2010	1		1. 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2^{Day} Amy Ellen Polson Gillie 2010 11:39 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Laurel Regional Hospital Laurel Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Days Hours 3/4/1963 Director 47 None UT Usual Residence of Decedent show 10a. State 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 23a or 28a-f 1 🗆 Yes 2 🔀 No Shelley Bingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1415 North 950 East 83274 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hyglene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 5 þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: If Yes, Give Year or Dates "natural" 3 - Widowed 4 - Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Ernest Polson Ann Hansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 David Gillie - Husband 1415 North 950 East Shellev, ID 83274 njury or other tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or or once. 1 D Burial 2 D Cremation 3 A Removal from State 4 Donation 5 Other (Spec Tavlor Cemeterv 7/28/10 Shellev 22. Name and Address of Facility Harry H. Witzke's Family F.H. 21. Signature of Funeral Service Light M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovación 4 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immediate Examiner cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of g physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical law requires that the death certificate be 68760 attending for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months?
1 Yes 2 No
9 Unknown 1 ☐ Live Birtin ∠ ☐ rotal acc.
4 ☐ Pregnant at time of death
9 ☐ Unknown ed by the a NA P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy Hospital or Attending Physician: The I. 24 hours after death. Funeral Director: After this certificate h performed? 1 Yes 2 No 2 1 Division of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 - No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 oply one 29b. Sign and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) mO DO067210 24/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

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KHIRBAS

31. Date filed (Month, Day,

Barbara Lee Glendinning State of Maryland / Department of Health and Mental Hygiene 2010 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Time of Death Medical Examiner Barbara Lee Glendinning 1058 hrs July 30, 2010 7-31-10 4a, Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Cambridge 907 Radiance Drive Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 213-64-2339 Months Davs Hours Director 55 Sept. 4, 1954 1 M 2 X F CountryMaryland Yrs Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d Inside City Limits Maryland Dorchester Cambridge 1 Yes 2XX No with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Radiance Drive 21613 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes Pages I and 2 should be filed within 72 hours after to nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "naturaly, on yother traumatic event, the Medical Examiner in If Yes, Give Year 3 Widowed 4 X Divorced 1 Yes 2XX No specify. Specify: White ş or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Nurse Nursing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ivy L. Hinson Be Sylvia R. Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allison Glendinning/daughter 700 7th St., SW #627 Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 8/3/2010 Baltimore, Maryland 4 Donation 5 Other Specify. 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signal re of Funer 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Hyperthermia complicating seizure disorder Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and sician/Medical g physician a X UNPENDED **AMENDED** Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth attending 2 Fetal death 3 Ectopic pregnancy Day Month Year use as past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown Unknown signed by the a Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? र्ठ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been s , page 2 should t 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed' death? Yes 2 No 2 No 1 🗸 Yes funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 V Yes 2 No 28d. Describe how injury occurred subject 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural exposed to high environmental temeratures the f Pending 1 Yes 2xx No 24 hours after death. To the Funeral Director: 7-31-10 10:57am 2 X Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined residence 908 Radiance Dr. Cambridge, M4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) August 1, 2010 O.C.M.E erson who completed cause of death (Item 23a) 30. Name and address of p Jack Titus MD. / Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Aurelia J. Grindrod July 18 2010 1:03 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth
(Month, Day, Year)
NOV • 12, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F **Director** 273-14-9997 88 1921 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a USA 43 West McKinsey Road, # 317 21146 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 💢 No If Yes, Give "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 X No Specify: Specify Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medico 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker **Home** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Theophil Kaufhold Joanna Otting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Strader / Daughter 208 Canterwood Court Annapolis, MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Baltimore, MD Metro Crematory, INC Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part 1 Enterthe discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Respiratury Medical Due to (or as a consequence of) Examiner 30 mins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) signed by the attending physician and defected for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hype-calcomia 2 No 3 Probably 4 Unknown 1 Yes page 2 should peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 No 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 R. dgel unuc Annon Meitl Goulet 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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David Antonio G		1- For State	Sta	te of N	laryland .		artment c <i>rtificate c</i>			nd Men	tai Hyg		D N-	201	0 :	2484
Physici		Registrar 1. Decedent's Name	e (First, Middle,	Last)			,				2.	Date of De				of Death
Medical Exami	ner		vid A n t			Gui	11en					Month July 20,				4 hrs
		4a. Facility Name (i Prince Geor		_	,				, Town, o verly	r Location o	of Death			c. County of De Prince Geor		
Funeral Director		5. Social Security N		Sex		e (In yrs. I	last birthday) Yı	Mont	ths Da		Min.	8. Date of E	,	1/DD/YYYY) 9. For		State or Salvado
'n		Usual Residence of	Decedent 10b. County			10c City	, Town or Loca	ation							I 10d In	side City Limits
d how any		MD	Prince	Geo	roe	TOO. ONLY		Carro	o11+	o n						Yes 2 No
Aaryland 28a-f show Latonce.	Director	10e. Street and Nur			160		New		ip Code	OII			10g. Ci	itizen of What C	ountry?	
the M a or 2 tified	ä	5704 83rd	d Place						207	84			E	1 Salva	dor	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heatht and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other trawmatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Marrie	ed 2 X Mar	ried A	Was Decedent Armed Forces?	V ∽				ispanic Orig ın, Mexican,			lo-	14. Race - Am White, etc		an, Black,
ifter de Il", or		3 Widowed	4 Divor	ced if Yes, or Da	Give Year	No No	1 🗓	Yes 2	2 N	specify:	Salva	dorar	ı	Specify: Hi	sp ani	с
nours a	ed by	15. Decedent's Ed		y only high	nest grade com		16a. Decede			ation (Give I			16b.	Kind of Busines	s/Industry	
36 in 72 h	plet	Elementary/Seco	ondary (0-12)	C	ollege (1-4 or 5	5+)						,	,	71		
21215-0036 Juld be filed within 72 hours af Mental Hygene. marked other than "natural ic event, the Medical Examin	Completed	9 L II 17. Father's Name (First, Middle, L	ast)			Elect	rici	an	18.Mother	's Name (F	irst, Middle		Electric	elty	
215 be file stal Hy ked o	Be		erra	,						Reg	ina G	uille	n C	icili an o)	
e, MD 2121 1 and 2 should be f Health and Mental item 27 is marked	힏	19a. Informant's Na								et and Num	ber or Rur	al Route N	ımber, (City or Town, Sta	ate, Zip Co	de)
and 2 shou sealth and N tem 27 is n		Ana Victo		nos	(Sist									MD 20784 Location - City		
Baltimore, Nemir Pages 1 and Department of Health Important: If item injury or other trau		20a. Method of Disp 1 X Burial 2		3 Re	moval from Sta	ite	Place of Dispo crematory or o	ther place	e)	emetery,)ate		·	,	
timent trant:		4 Donation 5				Fan	nily Ce				07-3			uachapa		
Baltimore permit. Pages 1 Department of I Important: If		21. Signature of Fu	neral Service Li	censee	V CCC	0010	34	Name and	α Addres Δth	St N	W.H.	Baco	n F	uneral in, DC 2	Home,	Inc.
Physician		23a. Part I. Enter th				the death									Appro	ximate Interval
/Medical Examiner		Immediate Cause (I	ly one cause or Final disease		rocution										Betwe	een Onset and Death
LAdilliller		or condition resulting	ng in death)	Due to	(or as a conse	quence o	of):									
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ted I Insit	ш	events resulting in	death) Last	Due to	(or as a conse	quence o	rf):									
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760, icate be executing physician and the burial - train	Physician/Medical	IF FEMALE:		230	. If yes, outcom	ne of preg	nancy						23	3d. Date of deliv	ery	
Box 68760 e death certificate be the attending physical defor use as the bu	ian/	23b. Was decedent past 12 months		1 [Live birth Pregnant at	time of de	noth -	etal death		Ectopic	pregnancy	/		Month	Day	Year
Sox death of e atter	ysic	1 Yes 2 N	lo 9 🔲 Unkn	own 4 9	Unknown	unie or de	eath 5 0	ther (Spe	ecify)							
that the dended by the		Part II. Other signif	ficant condition	ns contri	buting to death	but not r	esulting in the	underlyin	ng cause	given in Pa	rt I.	23e. Did	tobacco	use contribute	to the caus	e of death?
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Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be a page 2.		27. Manner of Death 1 Natural	n 5 Pendin		Ba. Date of Injui (Month, Day,Ye OUND:	ry ear)	28b. Time of FOUND:	Injury		ury at Work Yes 2	lRe	e-wiring 6	electri	jury occurred city during b	uilding re	emodeling
Sistem Atten at death	cati	2 🗸 Accident	Investig	gation J	ul 20, 2010 8e. Place of Inj	urv - At he	1455 hrs	et factor				f. Location	(Street	and Number or	Rural Route	Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	3 Suicide 4 Homicide	6 Could I	not be	Specify) Are	-						or Town.	State)	t, District Heig		,,
Hosp. 24 hou Funci		29a. Certifier		sician: To	the best of my	knowled	ge, death occu				ice, and du	e to the cau	use(s) a	nd manner as st	ated.	
To the within To the Comple	Medical	one) 2 🗸		ner:On the	e basis of exan nanner stated.	nination a	nd/or investiga				curred at th	e time, dat		lace, and due to		
2	Σ	29b. Signature and	title of certifier	1/0	10			29		se number				Date signed (A	fonth, Day,	Year)
6		Car	de	HER	Mo	-			O.C.	.M.E.			Jul	y 21, 2010		
		 Name and address Carol Allan, 						Street.	Baltim	ore, MD	21201					

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 4 2 7 J世中916,2010 Physician/ Reinaldo Baez Gomez Luis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital Social Security Number 214-71-3450 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X**M 2 □ F 1 1/27 /3 943 Hours Min. Co Yombia Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Silver Spring 10a. State MD 10b. County Montgomery 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 H No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20906 Colombia 15010 Dinsdale Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Colombian White If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 1 0 College (1-4 or 5+) Auto Parts Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ana Maria Gomez Rosendo Baez Pena 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15404 Thompson Road Silver Spring, Md20905 19a. Informant's Name/Relationship (Type, Print) Luis Mauricio Baez/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem 7/22/2010 Beltsville, Md 4 Donation 5 Other (Specify) PATAMETA ADERINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Intracranial hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner mD Sequentially list conditions, Examine Due to (or as a consequence or): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 7 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the Funeral Director. After this certification is the funeral director. 25. Was case referred to medical Be of Vital 26. Place of Death (Check only one) Hospital: Other: 1 X Yes 2 🗌 No ျ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending ivision 1 Yes 2 No Fell 28 20/0 /フラシ M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number, City or Town, State) 19010 1179 996 determined 1402210 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the callse(s) and // anner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Jeff/rey

31. Date filed (Month, Day, Year)

26

1427

3,27

8600 Old Georgetown Rd. Bethesda, Maryland

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

P.Muench M.D.

July 20,2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #8, 8-2-2010, per FHDR, HCHD, dertificate of Death Reg. No. 2. Date of Death July Physician/ 2010 аМ Mark E. Hollingsworth 9:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 13338 Pipes Lane Sykesville 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min 1 X M 2 □ F 067097201 Yrs 48 Director 578-96-6483 Usual Residence of Decedent 23a or 28a-f shov and Mantal Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Howard Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 13338 Pipes Lane 21784 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛛 No within 72 hours after 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chief Financial Officer Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မှ Eileen Fitzsimmons Charles G. Hollingsworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13338 Pipes Lane Sykesville, MD 21784 Michelle Hollingsworth - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/04/2010 Marriottsville, MD Crest Lawn Mem. 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown the should be detached signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed 2 🗆 No certificate Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Box 68760 P.O. Records, or Attending Physician: The law of Vital Division

Maryland 21215-0036

Baltimore,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

State

Medical

29a. Certifier

29b. Signature and title of certifie

Registrar

Clement B. Knight,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1) 411 3

26

2010

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:30 A M Meta A. Harrison 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Months Days Hours Min. 4/16/1930 **Director** 212-28-6068 80 MD Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medi-al Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎦 No MD Howard Columbia 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 7110 Minstrel Way Rm. 124 United States 21045 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Randolph Harrison Mary R. Gluck other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8509 Streambank Way Ellicott City, MD 21043 Patricia Allen - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State any injury or 4 Denation 5 Other (Specify) Meadowridge Cemetery | 07/29/2010 Elkridge, MD 21. Signature of Funeral Service Licensee M00845 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc l 4112 Old Columbia Pike Ellicott City, MD 21043 23a, Part 1, Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death ... 5 yrs. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Vear signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Congestive Heart Failure Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a. Was an autopsy 2 XNo 2 🛛 No Yes 25. Was case referred to medical Division of Vital completed filled in by the funeral director. Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending s after death. 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mD. D56531 July 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Pkwy. #301 Columbia, MD 21045 Harry Li 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature

DHMH 17 Rev 7/2009

Registrar

			For State Registrar	State of Marylan	•	artment of H tificate of D		,	giene Reg. No. 201	0 21.01.5
	- · · ·		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia Medio		John	L.	Hanr	ahan		July	20 201	0 7:10 P M
	Examin	er	4a. Facility Name (if not institution, give str	,		4b. City, Town, or		l	4c. County of De	
gare - C	Francis		Kline Hospice F 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast hirthday)	Mt.	Airy If Under 24 Hrs.	☐ 8. Date of Birt		ederick Birthplace (State or Foreign
	Funeral Director			M 2 □ F 64	Yrs.	Months Days	Hours Min.	(Month, Day Jan	/ Voorl	Country) ennsylvania
	/land f show ed at	tor	10a. State 10b. County	10c. City	y, Town or Loc	cation				10d. Inside City Limits
	28a-	Director	Maryland Frederic	k Fre	ederick					1 X Yes 2 □ No
	ith the		10e. Street and Number	.		10f. Zip Code 21701			10g. Citizen of What C	
	eath w	Funeral	331 East 3rd Stree	2. Was Decedent Ever in U.S	S. 13, V	Vas Decedent of His	spanic Origin? (Sp	ecify Yes or No-		nerican Indian,
215-0036	a filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23a or 28a-f show deter than "natural", or items 25a or 28a-f show the Medical Examiner must be notified at	by	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Yes, specify Cubar		Rican, etc.)	Black, Wh	
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N D	led will Hygid	Be	17. Father's Name (First, Middle, Last)	4	0100	LIIICI	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
/lan	should be fil and Mental is marked raumatic ev	욘	John K. Hanrahan				Sarah	Lyon		
Maryland	: 1 and 2 should be of Health and Ments f item 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Type	, Print)		-			; City or Town, State,	1 1
	and 2 Health em 2; ther t			20h P	Place of Disno	sition (Name of	- :	Date	20c. Location - City	ticut 06032
baltimore,			1	emoval from State	emetery, crem t. Mary	natory or other place		y ₂ 24,	Avon, Con	nnecticut
Ball	permit. Pag Department Important: any injury o		21. Signative of Fun rai Service Licensee	Deute	22	Name and Addres tauffer 621 Opos	s of Facility Funeral sumtown	Homes, Fr	ederick. N	4d. 21702
	Medical Examiner	ər	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	cause on each line. Due to (or as a consequ	Lem uence of):	er the mode of dying	, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
09/	icate be executed physician and s the burial-transit	ledical Examiner	if any, hadding to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequ	,					
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s, F.C	signed k	by	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			to the cause of death? Probably 4 Minknown
Vital Records,	aw requi as been 2 shoult	Completed						24a. Was a	sy prior t	autopsy findings available o completion of cause of
T T	t: The licate h			·· <u>·</u>	····· ·			1 Tyes	rmed? death	? /es 2 🗆 No
Ital	sician s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 Ho	spital:	EP/Outpotion	Lothe	r:		c. M.huh (C.	Harro
n 01 \	ding Phy h. After this funeral d		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		lence 6 A Other (Sp. ow injury occurred	ecity) 10011CE
DIVISION	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director, After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detached.	Certificate:	 Z ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 	28e. Place of Injury - At ho building, etc. (Specify			163 2 1110	28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
ם	Hospital 24 hours Funeral sted filled	Medical	(Check /2 Medical Examine		n and/or invest	igation, in my opinio	n, death occurred a	at the time, date a	nd place, and due to th	e cause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 L Certifying Nurse I 29b. Signature and title of certifier	Practioner: To the best of my	y knowledge, d	leath occurred at the 29c. License		1	e cause(s) and manner 29d. Date signed (Mor	
			> Censel	m)		NG:	3104		7/21	12010
	1		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, P	rint)	2 (4	- C /w	20	
	(e Stat	6	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture *	(reach	ick !	M 511	Uds	
	Registra		JUL 23	2010 Deneura	· A.	parke				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Peggy Jean Hitch 2:17 P July 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 18324 Wharf Lane Benedict Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F July 31, 1935 Months Days Hours Min. Washington, DC Director 217-30-6729 Usual Residence of Decedent 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 TNo Benedict Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18324 Wharf Lane 20612 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black White etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 X No 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72. th and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Donald H. Williams Mabel E. Wynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George R. Hitch/Husband 18324 Wharf Lane, Benedict, MD 20612 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 28, 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Brinsfield-Echols Crem. 4 Donation 5 Other (Specify) Charlotte Hall, MD 2010 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Ligensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complicative that clused the shock, or heart failure. List only one gar se on each line. ath. Do not enter the mode of dying, such cardiac or respiratory arrest Approximate Interval Between Oppet and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Oue to for as a nonsequence off Examin the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Yes 1 Yes 2 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an Arrer this certificate has funeral director, page 2: autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 2 40 Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar only one)

title of

of person

ompleted car

32. Registrar's Signature

29b. Signature and

30. Name and addr

31. Date filed (Month, Day,

ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date sign d (Month, Day, Year)

			For State	State of Maryland / D	epartment of l			2010	7 21.81.7
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Deam	2. Date of Dea	Reg. No. CUIL	3. Time of Death
П	Physici			oward			Month	25, 2010 Year	
And to	/Medio Examin		4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, o	or Location of Death		4c. County of De	14-17
A.C.			Citizens Care a	nd Rehabilita	Eion Fr	ederick		Freder	ick_
	Funeral		5. Social Security Number 6. Sex	IM OFF	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h 9. B	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	X 89	115.		8/11/1	920 P	Α
	yland now		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	a-fst	ctor	MD Freder	ick Fr	ederick				YPes 2□No
	iff th	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	Country?
	s 23a	era	1900 Rosemon		,	21702	N	USA	
10	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of F If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	14. Race - Arr Black, Wh	
036	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes \$Y∏ No If Yes, Give Year or Dates:	1 □Yes 2 X No	Specify:		Specify: W	hite
2-0	72 ho natur dical	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a.	Decedent's Usual Occup (Give kind of work done	oation during most of wor	kina 1	16b. Kind of Busines	s/Industry
121	/ithin ine. han "	jd m	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retire	d)			
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner rout be notified at		17. Father's Name (First, Middle, Last)		Home Make		ne (First, Middle,	Home Maiden Surname)	
au	d be ental ked o	To Be	Conrad Vickr	OV		Elsie	Hillm	,	
ary	2 should be t and Mental Is marked of aumatic ev	-	19a. Informant's Name/Relationship (Typ	pe. Print) 19b.	Mailing Address (Street				, Zip Code)
	and 2 ealth a n 27 ls		Patricia Lun	dregan	4206 Wasl	hington	Way Sy	kesville	,MD.21784
ltimore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "sactal Examble Traumatic event," the "sactal Examble		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State cemeter	Disposition (Name of y, crematory or other place		Date	20c. Location - City of	
Ē	t. Pages tment of l tant: If Ite		4 Donation 5 □ Other (Specify)	Fairf	ield Cemet		28/201p	New Flo	rence, Pa.
Ba	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service License	Papels 17101035	22. Name and Addre	I/ C			uneralHome Pa.15944
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do re cause on each line.					Approximate Interval Between Onsetand Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	alypeine	is Hise	erse			Turcos
1	/Medical Examiner		resulting in death)	Due to () as a consequence of	of):				
		ē	Sequentially list conditions, if any leading to immediate	Due to (or as a consequence of	4):				
	cuted nd ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
o	e exe		resulting in death) Last	Due to (or as a consequence of	of):				
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d.						
9 xo	eath certific attending p for use as	/Me	IF FEMALE:	Bc. If yes, outcome of pregnancy				201.5.1.11	
å	atter atter for u	Physician/Me	in the past 12 menths?	1 Live birth 2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	СУ		23d. Date of d Month	Day Year
о. О	at the de by the tached	hysi	1 □ Yes 2 No 9 □ Unknown	9 ☐ Unknown					
S, T	ulres that signed b	by P	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ğ	w require been sit should b	ted t	Cornel filme	later			1 🗆 Y	′es 2 2 √ uo 3 □	Probably 4 Unknown
ec C	law r las be	ple	Shroke / CVA				24a. Was a	an 24b. Were a	autopsy findings available o completion of cause of
<u> </u>	: The law cate has I page 2 s	Completed	,				perfor		?
Vital Record	sician: The certificate rector, page	Be	25. Was case referred to medical examiner?	ospital:	Oth	-	th (Check only or		
ō	Physer this eral dir	1:1	1 ☐ Yes 20 No	1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. T	patient 3 DOA	4 Nursing H		dence 6 Other (Sp now injury occurred	pecify)
0	nding F ath. : After e funera	atior	1 Natural 5 ☐ Pending	(Month, Day, Year) Ir	njury Wor	kí?]Yes 2. □No			
Division of	Hospital or Attending Physician: 44 hours after death Funeral Director: After this certific tely filled in by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (S City or Tow	Street and Number or i	Rural Route Number,
ā	spital or ours afte teral Dir filled in	Cer				10			
	To the Hospital or A within 24 hours after or To the Funeral Director Completely filled in by	edical	29a. Certifier Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge ler: On the basis of examination and and manner stated.	, death occurred at the ti d/or investigation, in my o	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	V	29c. Licens			29d. Date Rigned (Mb)	
			Enthron ? 1	loval CRNP-1	FIRC	28654	S	7/27/2	010
31	1-4		30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type, Print)	. /	A chi	1 do 11	010 1 21075
	Sta	te	31. Date filed (Mohth, Day, Year)	32. Registrar's Signature	o Mar	shall b	SV ZKK	viage 110	1 2/0/5
	Registra		1111 2 2 20		6.41				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

2010 24848

		1- For State Registrar			Ce	rtifica	ate of	Death			Re	g. No.		
Physici		Decedent's Name	(First, Middl	le,Last)						2	Date of Death		.]	3. Time of Death
Medical Exam	iner	9	Samue1	Manuel H	loston						July 15, 20			1916 hrs
*		4a. Facility Name (if	not institutio	n, give street and n	umber)		4	b. City, Town, or	Location of	of Death		4c. County o	f Death	
		Fort Washin	gton Hosp	oital				Fort Washir	ngton			Prince G	eorge	's
Funeral		5. Social Security N	umber	6. Sex	7. Age (In yrs.	last birth	nday)	If Under 1 Yea	r If Unde	r 24Hrs.	8. Date of Birth	h (MM/DD/YYYY)	9. Birt	hplace (State or
Director		,						Months Days				,	Foreig	Washington
		579-38-62		1 XM 2 F	. 22		Yrs.				05-31-	-1988	COL	nuth) DC
*		Usual Residence of 10a. State	Decedent 10b. County		10c. City	T	and annetic					****		10d. Inside City Limits
w an		Toa. State	TOD. County		Toc. City	, TOWITC	or Locatio	ori						
Maryland 28a-f show any d at once,	or	MD	Princ	e George		Ox	con I	Hi11						1 X Yes 2 No
faryl	ect	10e. Street and Num	nber		-			10f. Zip Code			10	g. Citizen of Wh	at Coun	itry?
r death with the Maryland or items 23a or 28a-f sho must be notified at once,	Director	220 Panor	ama Di	rive				20745				U.S.A.		
with 1	al	11. Marital Status	ama Di		cedent Ever in U	.S.	13. Was	Decedent of His	panic Orig	in? (Spec	ify Yes or No-		- Americ	can Indian, Black,
ath r	Funer	1 X Never Marrie	d 2 Ma	arried Armed F	orces?		If Ye	s, specify Cuban	, Mexican	Puerto Ri	can, etc.)	White	, etc.	
er de		3 Widowed	4 Div	1 Yes orced If Yes, Give Ye		- 1	1 🗀 .	Yes 2 X No	specify:			Specify:	D1 a	o.1r
rs af ural	by			or Dates: cify only highest gra		16a. D		s Usual Occupat		kind of wor	k done	16b. Kind of Bus		
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5-0036 led within 72 hours al Hygiene. other than "natural the Medical Examin	ple	Special Edu		.	,	١,	None					None		
with with	ompl	17. Father's Name (I	First Middle	Last)		1	NOILE		18 Mother	s Name /F	iret Middle M	aiden Surname)		· · ·
filed filed ed ot t, the	O	i i i i i i i i i i i i i i i i i i i		•						· ·		algeri odinano,		
21215-0036 und be filed within 7 Mental Hygiene. marked other than	o Be	Curtis 19a. Informant's Nar			26 . 1	1106	Mailing	Address (Stree			lliams	os City os Tour	Ctata	Zio Codo)
D 2 shoul and N aric	ĭ			•										
n, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medisal Examiner must be notified at once		Aishakara 20a. Method of Disp		ashidrida				norama ion (Name of cer				20c. Location -		
s langer litte				3 Removal f			ry or othe		netery,			200. Location -	City or	rown, state
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Realth and Mental Bygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		4 Donation 5	Other Sp			esan	eake	Cremate	orv	08-0	2-10	Beltsvi	11e	, Maryland
artm artm		21 Signature of Fun			1	,				W.H.				me, Inc.
		Maria	/i MI	ox CCC	25/			47 14th						
Physician	4	23a. Pagt I. Enter the	e disease, or	complications that of	caused the death	. Do not								Approximate Interval
/Medical		failure. List only	/	0 1 4	cations	o.f	for	1 alaah	01 6	mdro	m o			Between Onset and Death
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				h	a consequence e	1).								
	e	Sequentially list con if any, leading to imr		Due to (or as a	a consequence o	f):			·					
	aminer	(Disease or injury th		C									-	
n it	Exar	events resulting in d		Due to (or as a	a consequence o	f):								
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8760, ifficate be ex ng physician is the burial	§	IF FEMALE:		23c. If yes,	outcome of preg	nancy						23d, Date of	delivery	
68 certific nding se as t	au	23b. Was decedent p past 12 months?		LIVE	oirth		Feta	death 3	Ectopic	pregnanc	у	Month	D	ay Year
Box 687 Box eath certificate at the attending at for use as t	Sici	1 Yes 2 N	n 9 Unk	-	nant at time of de	ath 5	Othe	er (Specify)						
the de	Physiciar			9 Onkii							I co Birri			
ires that the signed by I be detach	by F	Part II. Other signifi	cant conditi	ons contributing t	o death but not r	esulting	in the un	derlying cause g	iven in Pa	rt I.				he cause of death?
sign Jbe											1 Yes	2 No 3	Proba	ably 4 Unknown
Records, The law requir ficate has been si	Completed										24a. Was ai autops			opsy findings available ompletion of cause of
e law e has	티			***							perforn	ned? de	eath?	
tal Rectian: The		OF Man ages refere	اممانه معمانه ما					OC Diese	of Dooth /	Charlesal	1 Yes 2	No1	✓ Yes	s 2 No
Division of Vital talor attending Physician rs after death. al Director: After this cert led in by the funeral direction	å	25. Was case referre examiner?	ed to medical	Lie a-itali					Other	Check onl			1	
F Vi Physi r this	유	1 Y Yes 2	No	- '-	Inpatient 2			o Don		Nursing F			Other	
Afte funer	崩	27. Manner of Death	_ }		n, Day,Year)	28b. II	ime of Inj		y at Work		id. Describe ho	ow injury occurre	d	
ior trend tor:	ä	2 Accident	5 Pend Inves	ing stigation				1 Y	es 2	No				
ViS or Al fter of jin by	ertification:	3 Suicide			e of Injury - At he	ome, fan	m, street,	factory, office be	uilding, etc	28	or Town, Sta		r or Rur	al Route Number, City
Di pital ours a filled	ert	4 Homicide	deter	mined (Specify)							Or TOWIT, Sta	ate)		
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certifind 24 hours after death. The Funeral Director: After this certificate has been signed by the attending repletely filled in by the funeral director, page 2 should be detached for use at	<u>a</u>			ysician: To the be										
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 🗸 N	Medical Exar	miner: On the basis	of examination a	nd/or inv	vestigatio	n, in my opinion,	death occ	curred at th	ne time, date a	nd place, and du	e to the	e cause(s)
To To con	Me	29b. Signature and ti	tle of certifier	and manner s	otaleu.			29c. License	number			29d. Date signe	d (Mon	th, Day, Year)
		0	126	Hall m	()			O.C.N	1.E.			July 16, 201	0	
	ļ	rame	×/ Cri	7		02-1						• "		
		30 Name and address		·	se of death (Item Medical Exa		111	Penn Street	Baltim	ore MD	21201			
									, Dastiill	J.C, 1VID	21201			
St Regist	ate	31. Date filed (Month	04 20	10 Page	egisirai s olguali.	140	eres	4						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month 0930AN Samuel Albert Jones 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's St. Mary s
5. Social Security Number Leonardtown Mary's Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1930 Maryland 1 X M 2 □ F Days Hours Min 80 Director 215-26-3608 April Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nortified one. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24575 Mount Pleasant Road 20636 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₺ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Jarrett Jones Annie Louise Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Snavely / Daughter 44547 Clarks Mill Road, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Leonardtown, Maryland July 28, 2010 Charles Memorial Gardens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 21. Signature of Funeral Service Licensee Kenneth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final schemic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to mini educate cause. Enter Underlying Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying of 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 062213 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) yresh 31. Date filed (Month, Day, Year) State JUL 26 2010 Registrar

Dog

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24850 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 20 TO 11:00A M Martha Jenkins 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1179 Summerfield Rd. Gambrills Anne Arundel 8. Date of Birth Marth, Ony, 12921 9. Birthplace (State or Foreign M名中が1and 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 1 □ M 2**X** F 89 213-22-2041 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2X No Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1179 Summerfield Rd. 21054 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: Black 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th 0 Restaurant Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eliza Carr William Ridgley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 Kinghaven Ct. Gambrills, Md. 21054 Harry Jennings (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Mt. Tabor UM Church 7-22-10 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wmame Reaseof Acid Sons Mortuary, P.A. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of)

Physician Medical Examiner

Physician/

Medical

Director

Funeral

þ

Completed

Be

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natu jury or other traumatic event, the Medical

permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after ceath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invertal director, page 2 should be detached for use as the burlar-transit is been signed by the should be detached

Records, P.O. Box 68760

Division of Vital

Physician/Medical Completed by Be မ Certificate: Medical

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OPD 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death
Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 7/2009

State

Registrar

OMILLIOND

completed cause of death (Item 23a) (Type, Print)

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OUNC- HYMAN

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ast 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J_{u1y}^{Month} 2010 1029 A^{M} Edith M. Jenkins Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Ceci1 286 Hollingsworth Manor E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. JAN 14, 1926 Maryland 84 **Director** 219-22-7802 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No Ceci1 Maryland E1kton 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 286 Hollingsworth Manor 21921 United States 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. George Rinkerman Minnie Meekins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Street, Jr./Son Hilltop Road, Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ju1v cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gilpin Manor Memorial Park 🛚 2010 Elkton. re of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signa 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Hypertension 3 years disease or condition Medical resulting in death) Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease **Examiner** ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SCIPIDEMIA 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate 1 Yes 2 No Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? 6 Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? Division Accident 1 🗌 Yes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ▶ 9th JULY 29,2010 00059223

State Registrar 30. Name and address of person who completed cause of

Nor

31. Date filed (Month, Day, Year)

Street

DHMH 17 Rev 7/2009

of death (Item 23a) (Type, Print)

32. Registrar's Signature

Elkton

Melchor E. Madarang,

Mary

M. D.

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Teresa Elizabeth Koller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical Contor 1 a Plata **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Widcal Examination until by multified anonce. Be Completed by Funeral Director holler, Teresa M193502 ၉ **Physician** /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

Civista Med	dical C	enter			La Pl	ata		Cha	arles	
5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1		er 24 Hrs. 8. Da Min. (M	te of Birth onth, Day, Ye	9	Birthplace (State or Foreign Country)	
217-36-5347	1□M 2XIF	91	Yrs.	Months D	ays Hours	Octo	ber 6	. 1918	Wisconsin	
Usual Residence of Decedent										
10a. State 10b. County	a. State 10b. County 10c. City, Town or Loc							10d. Inside City Limits		
Maryland Charles Benedi				t					1 □ Yes 2 🙀 No	
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?		
18523 A Street				20612				USA		
11. Marital Status	S. 13. V	13. Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			s or No-	No- 14. Race - American Indian, Black, White, etc.				
1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give				1 ☐ Yes 2 ☐ No Specify:			610.)			
3 ☐ Widowed 4 ☐ Divorced	'	Thes ZAINO Specify.				Specify: White				
15. Decedent (Specify only highes	s Education	1	16a. Deced	ent's Usual C	Occupation	ost of working	16b	. Kind of Busir	ness/Industry	
Elementary/Secondary (0-12)	life. D	(Give kind of work done during most of working life. DO NOT use retired)								
8	Fan	Farmer				Farming				
17. Father's Name (First, Middle, L	.ast)			18. Mother's Name (First, Middle, N				vlaiden Surname)		
Wenzel Koller				Mary Koller						
19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailing	g Address (S	treet and Num	ber or Rural Rout	e Number, Ci	ty or Town, St	ate, Zip Code)	
Joan Clark/Frie	nd		P.	O. Box	1, Hu	ghesvill				
20a. Method of Disposition	0 □ D	. C	lace of Dispos emetery, crem	atory or othe	r place) !	Date	i		ty or Town, State	
1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (Sp		State Brin	nsfield	l-Échol	ls Cre	07/24/2	010 Ch	arlott	e Hall, MD	
21. Signature of Funeral Service L	icensee	well !							uneral Home, P 11, MD 20622	
23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death										
Immediate Cause (Final disease or condition resulting in death)	_a	eu.	2 mg						X DANS.	
rooding in dodny	Due to	(or as a consequ	uence of):	1	1 C 1	meal	(00)	11		
Sequentially list conditions,	b. 170	NAMO	MAI	211	51/1	-OSCL	UVU.	177.	- K - Mas	
if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	uence or):						V.	
that initiated events resulting in death) Last	c	(or as a consequ	ience of):							
	Buc to	(or as a consequ	acrice ory.							
	d									
IF FEMALE:	000 16									
23b. Was decedent pregnant in the past 12 months?	1 🖵 Live	tcome of pregna birth 2□Fetal	I death 3 🗍	☐ Ectopic pregnancy				23d. Date of delivery Month Day Year		
1 □ Yes 2 Mo 9 □ Unknown	4 ∐ Preg 9 ☐ Unkn	nant at time of d	eath 5□	Other (speci	fy)			World	Tou,	
			oldin — i — din —	deal de escen	tt- B		Did toboo	1	ute to the serves of death?	
Part II. Other significant conditions contributing to death but not resulting in the un									ute to the cause of death?	
						_	1 ∐ Yes	2 No 3	☐ Probably 4 ☐ Unknown	
						24	a. Was an		ere autopsy findings available or to completion of cause of	
							autopsy performed ⊒Yes 2 🔼	l? dea	ath? ☐Yes 2 ☐ No	
25. Was case referred to medical					26 Pla	ce of Death (Chec		140	Ties ZIINO	
examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient	3 □ DOA	Other:	Nursing Home 5		a 6 □Other	(Spacify)	
27. Manner of Death	28a. Date	of Injury	28b. Time of		Injury at Work?			njury occurred		
1 Natural 5 ☐ Pending 2 ☐ Accident investiga		th, Day, Year)	Injury	М	Work? 1 ☐ Yes 2 [□No				
3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place	of Injury - At ho	me, farm, stre	et, factory, of		28f. Lo	28f. Location (Street and Number or Rural Route Number,			
4 Homicide	ng, etc. (Specify		City or Town, State)							
29a. Certifier 1 ertifying	Physician: To the	best of my know	wledge, death	Occurred at t	the time date	and place, and du	e to the caus	e(s) and man	ner as stated	
(Check only 2 Medical E	xaminer: On the b	asis of examinat	tion and/or inv	estigation, in	my opinion, d	eath occurred at the	ne time, date	and place, and	d due to the cause(s)	
29b. Signature and title of certifier	A 1			29c. Lj	cense number	r	29d.	Date signed (Month, Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

24852

3. Time of Death

3:00 PM

Reg. No.

4c. County of Death

2. Date of Death

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

attending physician and for use as the burial-trar

After this certificate has been signed by the funeral director, page 2 should be detached

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 23, 2010 Virginia Margaret 1:10 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arden Courts Assisted Living Potamac Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 31, 9. Birthplace (State or Foreign **Funeral** Country) New York Months Davs Hours Min. Director 056-14-7527 90 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2X☐ No Maryland Mon topmery Potamac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10718 Potomac Tennis Lane 20854 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 XNo
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important, If item 27 is marke any Injury or other traumatic once. Frank Clark Caroline Harsfeldt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha M. Kidd/Daughter P.O. Box 3187, Merrifield, VA 22116 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) 2010 Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Wehard L . Hates 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 yrs. Immediate Cause (Final Physician. Metastatic NonHodgkins Lymphoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes XX No 23d. Date of delivery 3 Ectopic pregnancy ρď Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown been signed by the sahould be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Advanced Dementia, Lower Extremity Deep Vein Thrombosis Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 Yes Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA

After this certificate funeral director, 24 hours after deat Funeral Director: completed filled in by the

၉ Certificate:

Medical

29a. Certifier

(Check

only one)

2 1 No 1 Yes

27. Manner of Death 1 🔀 Natural 5 Pending Accident Investigation Suicide

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28a. Date of injury (Month, Day, Year)

29c. License number D61382

28c. Injury at work? 1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

July 23, 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shama R. Mittal, MD 10718 Potomac Tennis Lane, Potomac, MD 20854

State Registrar 31. Date filed (Month, Day, Year) 26 201

29b. Signature and title of certifier

ama

32. Registrar's Signature ach

within 2 To the I

P

28b. Time of

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Tuli HAL < iNG 85404 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Community Hospital ANhAm PRINCE ores GEORG 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth Funeral Days (Month, Day, 1 □ M 2 🖾 F 218-20-3375 94 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MARYLAND 1 🗆 Yes 2 🗷 No Wicomico SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KEAA 901 2180 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NONE EACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ MORRES 11:2 MAE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) King De. DALE G/ENN 11/0 20769 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Fune I Service I Ansee 22. Name and Address of Facility WEST FUNERAL HOME EWAR 23a. Part 1. Enter the disease, or complications that cn/sed t shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician doys disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, in any cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 5troke 24b. Were autopsy findings available prior to completion of cause of death? autopsy chole cust tos 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 22 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

and er, mi).

Registrar's Signatur

12700 Goodloes Promise Dr.

BOWIE, MD, 20720

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 **Physician** Mary Lenore Spencer Kinkel 22. Ju1y 2:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Collington Episcopal Life Care Center Mitchellville Prince George's 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. 483-10-0940 94 Director Jun 22, 1916 Towa Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner that be notified at Director MD Prince George's 1X Yes 2 □ No Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Exercises Once. 8250 Landover Road 20785 by Funeral USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Force 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2K No White Specify Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's County Elementary/Secondary (0-12) College (1-4or 5+) 6 Registered Nurse Medic<u>al Center</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Nelson Spencer ဥ Florence Sidwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold E. Wilson / Friend 16301 Colwell Dr., Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 7/24/10 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Claudette Basch Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Lanny 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): execut and burial-trar Due to (or as a consequence of) Box 68760, attending physician certificate be Physician/Medical the as use 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Por in the past 12 months? Month Day Year 4 Pregnant at time of death ☐Yes 2 No 5 Other (specify) P.O. ned by the a detached f 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Chronic obstructive pulmonary disease 1 Tyes 2 No 3 Probably 4 H Unknown Completed Advanced dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate performed Atrial fibrillation 1 □Yes 2X No 1 ☐Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🎛 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of on: After 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 K Natural 5 Pending the Funeral Director: A Certificati 2 Accident investigation 1 ☐ Yes 2 🗆 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month) Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Rexford Babilah, MD

7500 Hanover Pkwy, Ste 101A, Greenbelt, MD

JUL 2 7 2010 Semin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20**1**0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ 20, 8:30 p M Glen Richard Lambert July Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll 797 Velvet Run Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 X M 2 🗆 F Months Days Hours Min. (Month, Day, Year, 58 West Virginia 1951 Director 219-60-5005 Usual Residence of Decedent shov If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster 1 Yes 2 X No Maryland Carroll 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21157 Funeral 797 Velvet Run Road USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔼 No Yes, Give Š Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: White ould be filed within 72 hours aft d Mental Hygiene. marked other than "natural", Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Aide Direct Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other. Bessie Agnes Purtee James Marshall Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 797 Velvet Run Dr. Westminster, MD 21157 Barbara Lambert - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/26⁶/12010 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Finksburg, MD Hvergreen Mem Gardens 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part J. Enter the disease, or complications that, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has autopsy performed 1 🗌 Yes 2 🕱 No 1 🗌 Yes 2 🕱 No 25. Was case referred to medical Be examiner? Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2

Registrar DHMH 17 Rev 7/2009

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29b. Signature

31. Date filed (Month, Day, Year)

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ss of person who completed cause of death (Item 23a) (Whe, Print)

MA

THEW

32. Redistrar's Signature

29d. Date signed (Month) Day, Year)

LTIMORE BUD, FINKER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>010</u> Physician/ July 20, ICHARD AMBERI 0401 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min. Sep 24, Year 1936 73 New Jersey 137-28-0202 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Carroll Westminster 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1605 Old Taneytown Road 21158 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 \(\subseteq \) No 1954— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or Şq 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 1962 white Completed 3 X Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) U S Government Logistical Support Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Lambert Mabel Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4307 York Road #1, Millers, MD 21102 Susan M. Tawes, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadow Branch Cem 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/24/2010 Westminster, MD 22. Name and Address of Facility Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Lower Gastreidisease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any leading to immedi cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the a Yes 2 No g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 010 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 1 Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) WIL 2010 3+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER, MD 21157 WASHINGTON RD.

DHMH 17 Rev 7/2009

Registrar

13

ROBERT GORDON, MD

31. Date filed (Month, Day, Year)

826

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Girard Lee Jr. Ju1y 10:28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ⅓M 2 □ Months Days Hours 214-36-2777 71 117371938 Washington DC **Director** Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2565 Golfers Ridge Rd 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Year or Dates. 62-65 permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic event; the Medical Exponen. Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Lee-Warner (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Architects Architect Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Girard Lee Dorothy Thomas 19a. Informant's Name/Relationship (Type, Print)
Paula Lee – Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2565 Golfers Ridge Rd, Annapolis, MD 21401 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 7/23/2010 Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service License 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ eumonie disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ☐ Yes ∠ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Nes Other: မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accide 5 Pending 2 🗌 No Investigation Accident Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 1

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation in my opinion death and the cause of the cause Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

139

32. Registrar's Signature

D41816

Old Solvenors Island Rd. Annepolis

2140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month_1 Year 2010 Physician/ MARIA AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRUSCE 6000165 ADME)2216 Banning Place Hyattsville 6. Sex 1 □ M 2 🕱 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 95 Nicaragua Director 578-98-4621 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2216 Banning Place 20783 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: If Yes, Give Year or Dates <u>Nicaraguan</u> 3 Midowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic eve permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ Alnso Lopez Josefa Narvaez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tania M. Lopez/ Daughter 12415 Stonehaven Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/23/2010 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PLASEASE Onset and Death COROHARY ALTENY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): 720 YR1 **Examiner** PLABETE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) -transit The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Box 68760 the IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 4 Pregnant at time of death Month Dav Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DENTENSLA Records, 1 Yes 2 No 3 Probably 4 Unknown DYSUPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy STENOSI CHRONIL performed' 2 2 No 2 🗗 N Yes To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 MO မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Watural 5 Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) do wadkow no Sk 3010 20602 3261 ALGA LEON 31. Date filed (Month, Day, Year) Fegistrar's Signature State 1 2010 JUL Registrar

	1	For Amend#2,2016 per PHYState of Maryla = State Registrar 7/26/2010 AACO HEALTH DEPT.C	MH Cer	tificate of D			Reg. No.	24860	
Physician/		1. Decedent's Name (First, Middle, Last) Jeffry J. Loichinger				2. Date of Dea		3. Time of Death 6:29 p M	
Medical Examiner		4a. Facility Name (if not institution, give street and number)		Location of Death		4c. County of Dea	th		
Funeral	Į.	111 Earliana Court 5. Social Security Number 6. Sex 7. Age (In yr.	Pa If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birtl	n 9. Bi	thplace (State or Foreign		
Director		374-58-8406	(Month, Day April 1	3,1952 M	ichigan				
yland f show ad at	- 1-	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit							
or 28a- or or 28a- or Direct	<u> </u>	10e, Street and Number	10f. Zip Code			1 ☐ Yes 2 🕅 No 10g. Citizen of What Country?			
leath with the Maryland items 23a or 28a-f sho er must be notified at Elmeral Director	Let a	111 Earliana Court	21122			USA			
, ra	3	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	- 1	 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 			o- 14. Race - American Indian, Black, White, etc. Specify: White		
21215-003 vithin 72 hours af liene. r than "natural" the Medical Exe	-	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I	lent's Usual Occupa kind of work done di O NOT use retired)	ation luring most of work	king	16b. Kind of Business Industry		
d 21; led withi Hygiene Other the		17. Father's Name (First, Middle, Last)	Sa	ales	18. Mother's Nam	ne (First Middle I	Aircraf Maiden Surname)	t	
ylano Id be file Mental arked c atic eve		Anton J. Loichinger			Joanne	,	viadon damamoj		
Marylk 2 should b Ith and Me 27 is mark r traumatic		19a. Informant's Name/Relationship (Type, Print) Carol L. Loichinger / wife					; City or Town, State, Z	p Code)	
Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examonce. To Be Completed by	1	20a. Method of Disposition 20th	Place of Dispo cemetery, cren	sition (Name of natory or other place		Date 23 Y -22, 2010	20c. Location - City of		
Baltin permit. Pa Departmet Important any injury	ŀ	4 □ Donation 5 □ Other (Specify) 21. Signature if Fun 1 Service Licensee		ematory, Name and Address arranco &			Baltimore erna Park F	uneral Home	
— 40 = 60	1	23a. Part 1 Inter the disease, or complications that caused the de	149	95 Ritchi	<u>е нwy, </u>	Seve	rna Park,	Approximate	
Physician/ Medical	7	shoot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to		Interval Between Onset and Death					
Éxaminer		Sequentially list conditions b CSON	a. Upper gastrointestinal b Due to firms a consequence of: CSOPHAGEAL VARICES					One year	
xecuted nand al-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		one year five year					
a crist		that initiated events resulting in death) Last C. Due to (or as a const	-						
8760 tificate be end physiciar as the buria		F FEMALE:							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the b Medical Certificate: To Be Completed by Physician/Medic	in parameter in	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 Pregnant at time of g Unknown	Ectopic pregnancy Other (specify)	у		23d. Date of delivery Month Day Year			
S, P.O iries that to signed book detailed by P.O.O.O.O.O.O.O.O.O.O.O.O.O.O.O.O.O.O.O	ה	Part II. Other significant conditions contributing to death but not	en in Part I.	art I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Probably 4 Unknown					
Records, The law require: cate has been si; page 2 should t			sy prior to death?	utopsy findings available completion of cause of					
/ital sician: certific irector,	3	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	fi	_ Tothe	ace of Death (Chec				
ivision of Vii or Attending Physia after death. Director: After this on in by the funeral dire Certificate: To		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation			28c. Injury at work? M 1 Yes 2 No		ence 6 Other (Spec ow injury occurred	city)	
Division all or Atternation and in Directord and in by the Control of the Control						28f. Location (Street and Number or Rural Route Nu City or Town, State)			
he Hospita in 24 hours he Funeral ipleted filled		(Check 2 Medical Examiner: On the basis of examina	igation, in my opinior	ured at the time, date and place, and due to the cause(s) and tion, in my opinion, death occurred at the time, date and place, th occurred at the time, date and place, and due to the cause(s)			cause(s) and manner stated.		
_		29b. Signature and title of certifier	29c. License	number	29d. Date signed (Mont	te signed (Month, Day, Year)			
MA 3	3	30. Name and address of person who completed cause of death (If	_		Pasad	a M) 2112>		
State Registrar	3	31. Date filed (Month, Day, Year) JUL 2 2 2010	nature Rec	CA KIND	Lazao	/	1 2112		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State AMEND#23aII, 25, 27, 28a-fiperMD, 7/21/2010 certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>010</u> Physician/ Month 4:15 A. M Joe M. Long 19 July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Health Services Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day,) Aug. 3 9. Birthplace (State or Foreign **Funeral** 1 🗙 M 2 🗆 F Months Days Hours Min 578-03-7979 Director North Carolina 1918 Auq. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Chevy Chase Montgomery 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8101 Connecticut Avenue 20815 United States within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Yes 2 No
If Yes, Give 1940–1941
Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White and Mental Hygiene.
is marked other than "natural", raumatic event, the Medical Exal 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Broker Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joe R. Long Carrie Ρ. Sragins permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Elaine D. Long/Wife 8101 Connecticut Avenue, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery crematory or other place)
Geo, Wash. University
Medical Center 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 2010 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. f Funera /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition a Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 2 🗆 No been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Subarachnoid Hemorrhage due to fall at home 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has prior to death? autopsy nin 24 hours after death.

The Funeral Director: After this certificate hapleted filled in by the funeral director, page performed? Yes 2 🔼 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner/ 1 X Yes 2 No Hospital Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Avatura 5 Pending work? 1 ☐ Yes 2 🛣 No 2 X Accident Fell hitting head on filcon Investigation 6-25-2010 <u>unknown</u> M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 81617 or Town, State out Avenue within 24 hours a Home Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D52261 July 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1517 Hugo Circle

Registrar DHMH 17 Rev 7/2009

State

Alan R. Segal,

6

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

backer

Silver Spring, MD 20906

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 24, 2010 2:53 p Thick Lee Tsuna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Pay, Year) Dec. 26, 1932 6. Sex 9. Birthplace (State or Foreign **Funeral** Country) China 579-98-0524 Days 1★ M 2 □ F Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🗆 Yes 2 🌁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1001 Whitehall Street 20901 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify Asian 1 ☐ Yes 2 X No Specify: d Mental Hygiene. marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Chef Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Soon You Wong Cheng On Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1001 Whitehall Street, Silver Spring, MD 20901 Kun Luan Chu/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔲 Burial 2 🛣 Cremation 3 🗀 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring ,MD 20901 21. Signature of Juneral Service Licensee Nichard L Hates 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗆 No 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed? Yes 2 No death? 1 Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

that the death certificate be executed 68760 Box P.O. Records, **Division of Vital** Hospital or Attending hours after death.
neral Director: Aft 24 hours a

To the within 2 To the I

State Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

JUL

 Name and address of person who complete Daniel K. Sherk, MD 31. Date filed (Month, Day, Year)

2 6 2010

d cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road,	Silver	Spring,	MD 20910
22 Pagiotraria Signatura			

🖺 Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

d67355

29c. License number

City or Town, State)

29d. Date signed (Month, Day, Year)

July 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Virginia Lee Layfield July 21, 2010 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Wicomico Salisbury **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 🖺 F Months Days Hours Min. 214-28-3714 80 Director Maryland 12/10/1929 Usual Residence of Decedent with the Maryland show 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director DE Sussex Delmar "natural", or items 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8663 Delmar Road Funeral 19940 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Donovan Evelyn Segars ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William J. Layfield /spouse 8663 Delmar Road, Delmar, DE 19940 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St Stephen's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 07/24/2010 Delmar, DE 22. Name and Address of Facility 21. Signature of Funeral Service License 6 Short Funeral Home 13 E Grove St, Delmar, DE 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Myocar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of): Due to (or as a consequence of Box 68760. Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Yes 24 No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 Other (specify)

To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Division of Vital Records, Director: filled in by the

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

Day

Year

Approximate Interval Between Onset and Death

0053 а_м

10d. Inside City Limits

White

1 ☐ Yes 2 No

23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 🗌 No 3 Probably

24a. Was an autopsy 1 ☐ Yes 2 1No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 \(\text{Homicide} \)

Certification: To

Medical

State Registrar

examiner?

25. Was case referred to medical

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 Inpatient

2 R/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of perlifier

License number 31546

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 24 hours after To the Funeral Dire

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Mahon 8:50A Ju₁y 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3433 Azalea Place, Unit B Waldorf Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 x M 2 □ F 130-46-4155 53 August 4,1956 **Director** New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3433 Azalea Place, Unit B 20602 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher High School other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nt of Health and Mental H t: If item 27 is marked oth or other traumatic even Be Eugene J. Mahon Lorraine Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Mahon/Sister 905 Palomas Drive, N.E. Albuquerque, NM 87108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Brinsfield-Echols Crem. 7/28/2010 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22 ARTHART-ECHOLS FUNERAL HOME, P.A. M00945 211 St. Mary's Ave. La Plata.MD 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transil Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No as been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed page 1 ☐ Yes 2 The No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death. death. 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

within 24 hours a To the Funeral C completely 15

BBM State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certified

30. Name and address of person who

repleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Yea 32. Registrar's Signature 26

2010

Mathur, M.D.

1-critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Krishan

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Elaine Milstead 200 July 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carrol1 688C Poole Rd. If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Ye Jan 24 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year 1 M 2 F Director 1925 Marvland 579-20-3678 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Carroll Manchester Maryland 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21102 2110 Ebbvale Rd. USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan Leon/Caregiver 2110 Ebbvale Rd., Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carroll Cremation Inc:07/20/2010 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 22. Rividutas or Bunewal Home and Chapel, P.A. Jail. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that cased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medica resulting in death) Due to (or **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury 10 + YRS signed by the attending physician and a be detached for use as the burial-transit that initiated events Due to (or as resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Branchitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 🗌 Yes 2 🔲 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 4 Nursing Home 5 Residence 6 Sother (Specify) 6 F Other: 2 TANO Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation
6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) WIL 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Patricia Lane McDermott July P^{M} 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days Country Director 549-58-1341 67 July 9. 1943 California Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 No Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3939 Roland Avenue #103 21211 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Anthony Kelly Caroline Emma Boltus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any Injury or other trau Joanne Paladino/Niece Stanford Road W Rochester, New York 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/26/2010 Woodbine, Maryland 21. Signature of Funeral Service L Sing Home Cremation Service Beverly L. Heckrotte, P.A. Cla ce P.O. Box 784 Clarksville, MD uanita M00957 23a. Part A Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory disease or condition Medical resulting in death) Examiner Myocardial Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): law requires that the death certificate be executed coronary Severa arten resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical Records, P.O. Box 68760 se as t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Appendicitis 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Peripheral vascular Diseals 24a. Was an autopsy page 2 performed? Yes 2 No death? or Attending Physician: The CVA certificate 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after death.

e Funeral Director: After the pleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

within 2.

Charles St.

Baltimore MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

32. Registrar's Signature

6701

Patel

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Isabelle Dorothy Powers McShea Julv 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20613 Dubois Court Montgomery Village Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hr 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Davs Hours Min. June 9, Yel 934 76 Director Ohio 577-44-4222 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 tv Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 102 Kendrick Place #24 20878 United States items . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Legal Secretary Law Be permit. Page 1 and 2 should be filed or Department of Health and Mental Hyy Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Walter Powers Isabelle Dorothy Noble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Wilson/daughter 20613 Dubois Court Montgomery Village, MD 20886 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place ö 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/27/2010 Woodbine, Maryland . Si e of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M unita M00957 Clarksville, MD 21029 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 K No Day Month Year Pregnant at time of death detached 1 ☐ Yes 2 2 9 ☐ Unknown 9 I Inknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Lung Disease 1 X Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 X No certificate h 25. Was case referred to medical examiner? pleted filled in by the funeral director, æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify Daughter Hospital: S 2X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? iniury Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 🗀 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

5

(Check only one)

31. Date filed (Month

d title of certifie

Dennis A. Cullen,

leen

energy

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7625 Wisconsin Avenue, #101 Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

July 23, 2010

29c. License number

D40216

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 25 2010 2:00 p William Francis Miedzinski Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Maryland 1 🔀 M 2 🗆 F Months Hours 06/30/1937 Director 217-34-1909 73 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 Yes 2XXNo Maryland Great Mills St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45847 Belvoir Road 20634 II S A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed Specify: 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maryland State Police State Trooper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file alth and Mental H 27 is marked o ೨ McKay John Edward Miedzinski Mary Irva traumatic permit. Page 1 and 2 sh.
Department of Health an.
Important: If item 27 is m
any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary G. Miedzinski/ Spouse P.O. Box 754, California, MD 20619 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Immaculate Heart 07/30/2010 Lexington Park, MD 4 ☐ Donation 5 ☐ Other (Specify) Sig day Dueral Se e Dens Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAC MINUTES disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to lor as a considuence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of). attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Jas certificate 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: ٩ 1 Inpatient 2 KER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier McCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number D0057826

State Registrar 32. Registrar's Signature

BOX 524 LEONARDTOWN MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IBRADO

JUL 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** chae 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WashingTa tage 1stano 0 11510WM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number ூர் Sex 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2 □ F Yrs 213-18-9011 90 Director March 3,1921 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a or 2 iner must be n 14014 Marsh Pike 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. r than "natural", or Iten the Medical Examiner 1 X Yes 2 No If Yes, Give WW II Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Wher Elementary/Secondary (0-12) College (1-4or 5+) Home Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If Item 27 is marked ott any ligity or other traumatic even once. Be Earl W. Michael, Sr. Mamie Violet 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina L. Horst / Step Daughter 12817 The Terrace Hagerstown, MD21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory July 28,2010 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearing allure. List only one cause on each line. Fastern Blvd. North, hagerstown MD 21742 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 000001 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Solursing Home 5 Residence 6 Other (Specify) Hospital: 25 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurral transit Division or Vital Records, P.O, Box 68760,

WH4+1

Phanic 31. Date filed (Manth, Day, Year) State Registrar

29a. Certifier

29b. Signature and title of certifier

ahanu

Medical

- Concordic Registrar's Signature

BYTHER

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

140,14 Mersh Pike Hapers-Jum

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ruth Catherine McManus Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov. 5, 1918 **Funeral** Months Min. 91 Director 214-09-2518 Yrs Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1128 Security Road 21742 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces δ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 nan "natural", o Medical Exan 1 ☐ Yes 2X No Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 in the and Mental Hygiene. 27 is marked other than "r (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) dietary cook hospital Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roy Wetzel Sadie Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 slit of Health a Bonnie Brown - daughter 12835 Bradbury Ave., Smithsburg, Md. 21783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any Injury or ot cemetery, crematory or other place) ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Hagerstown Crematory 7/28/10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses MINNICH FUNERAL HOME 22. Name and Address of Facility 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consuluence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No ed by the Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an page 2 s autopsy Yes 2 of Vital Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖺 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

WH-S

ORIGINAL

alka MD

OS an

Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2010

Washington

Black, White, etc.

white

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between

Onset and Death

1 Yes 2 X No

Maryland

State

10-05369 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Adolfo Antonio Meiia State of Maryland / Department of Health and Mental Hygiene 2010 24872 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mejia Adolfo Antonio Rivas Medical Examiner July 18, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore University Hospital 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY Funeral 42 Months Hours Days Director none 1 M 2 F 3/26/1968 Usual Residence of Decedent any 10a State 10b County 10c. City, Town or Location Chester MD Queen Annes is 23a or 28a-f show be notified at once. or 28a-f show Caltimore, MD 21215-0036 cert Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. rector 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? El Salvador 21619 223 Dominion Road 靣 Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) El Salvadoran 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. White 1 Never Married 2 Married Armed Forces? 2 3 Widowed Divorced If Yes, Give Year 1 X Yes 2 No specify: narked other than "natural", event, the Medical Examiner Specify: þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Dishwasher Restaurant 8 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname Santos Ramon Rivas Gallardo Consuelo Antonia Mejia marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Juan Carlos Rivas/Nephew 223 Dominion Road Chester, Maryland 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, or other 1 XBurial 2 Cremation 3 XRemoval from State Ceffeter 10 deneral |7/29/2010 De Aquilares 4 Dongtion 5 Other Specify 21. Signat re of Funeral Service **Physician** failure. List only one cause on each line. /Medical a. Stab Wound of the Head with Complications Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical the attending physician ied for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death 2 past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown signed by the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ. ۵. Completed of Vital Records, been 24a. Was an autopsy this certificate has performed? Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Division

20c. Location - City or Town, State San Salvador, El Salvador PHTETPADE THALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval 23a. Part I. Envir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 8etween Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi Other Nursing Home 5 Residence 6 Other 28d. Describe how injury occurred Certification: Jul 11, 2010 Subject stabbed 1 Natural 1300 hrs 1 Yes 2 V No Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 112 Kehm Road, Queenstown, MD determined (Specify) Single Family home 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 19, 2010 O.C.M.E. Nume Len 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, **2** 6 2010 32. Registrar's Signature State Registrar **ORIGINAL** OCME

3. Time of Death

1405 hrs

Foreign Edoun&alvador

10d. Inside City Limits

1 Yes 2 No

9. Birthplace (State or

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Leo Pope 2010 10:18 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8 Date of Righ 1 ☒ M 2 ☐ F Days Hours Min (Month, Day, September Director 578-34-9307 80 10,1929 Washington, DC Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 9335 Washington Blvd. 20706 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 1952 3 Widowed 4 Divorced Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail should be filed with and Mental Hygien? Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stephen Pope Margaret Ann Fitzpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Pope / Wife 9335 Washington Blvd., Lanham, MD 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Fort Lincoln Cemetery 7/31/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do t enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): ng physician as the burial Physician/Medical that the death certificate be 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE Ise 23b. Was decedent pregnant 23d Date of delivery Box ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 ☐ Yes ∠ ☐ Unknown s been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pertension Diseas Coronar Records, Completed 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Angina cate has be page 2 s Congestive Heart performed? Yes 2 2 🗌 No 1 Tyes or Attending Physician: Division of Vital 26. Place of Death (Check only one) examiner? 2 🔀 10 Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Direc completed filled in by Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MPD 61637 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) luck Road Good 0201 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla		artment of H tificate of L		and Me		20	010	24874
			Registrar 1. Decedent's Name (First, Middle	e, Last)		007	incate of L	Journ		2. Date of De	neg. Ner-	,,,	3. Time of Death
	Physicia		Patricia An	n Paris					Т	Month ulv	24	2010	
	Medic Examin		4a. Facility Name (if not institution		mber)		4b. City, Town, or	Location of		шту		unty of Death	
			Harmony Hall	Assiste	d Livin	g	Colum	bia				ward	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days			8. Date of Birl			hplace (State or Foreign
	Director		579-20-6884	1 □ M 2 🔀 F	85	Yrs.	IVIOITIIS Days	Hours	Min.	(Month, Da Nov 12	1924	_Wash	ington, DC
	ld now	Ŀ	Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Loc	cation				-		10d. Inside City Limits
	arylar a-f st fied	Director	MD Howar		1.55.5	Columb						1	1 X Yes 2 No
	or 28	ä	10e. Street and Number	. u		COTUNIO	10f. Zip Code				10g. Citizen	of What Cou	
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	tems er mi	F	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. V	Vas Decedent of H	ispanic Orig	gin? (Speci	fy Yes or No-	14. F	Race - Amer	
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Maryland	shoul and I is ma		19a. Informant's Name/Relationsi				g Address (Street a					n, State, Zip	Code)
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Brenda Cantrel	.1 / Daugl			Sweet Cl	over	Colu	mbia,		.045	
סב	ge 1 a		20a. Method of Disposition 1 Burial 2 ☐ Cremation		n State	cemetery, cren	sition (Name of natory or other plac	re)	Da	- 1		on - City or T	
Baltimore,	pernit. Page 1: Derartment of H Important: If it any injury or of		4 Donation 5 Other (\$ 21. Signaturg of Funeral Service)		Ft		1n Cemet	-				wood,	
Ra	Dere Impo			uclo		1	01 Blade		-		twood,		20722
			23a. Fart 1. Enter the differe, or shock, or heart fuller. List of	complications that	caused the dea	th. Do not ente	r the mode of dyin	g, such as	cardiac or r	respiratory arı	est,		Approximate Interval Between
	Physician/		Immediate Cause (Fin L disease or condition	Cor	onary A	rtery 1	Disease					- 1	Onset and Death
	Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):							
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consec	Tilence off:							
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	execu n and ial-tra	E	that initiated events resulting in death) Last	C. Due to	(or as a consec	quence of):	_						
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٥ ×	th cer tendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	tcome of pregn Birth 2 - Fet	tal death 3	Ectopic pregnanc	:y				Date of deli	
X P P	e dear the at hed fo	by Physician/M	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 ☐ Preg g ☐ Unk	gnant at time of mown	death 5 L	Other (specify)					Month .	Day Year
J.	at th	, Ph	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I	l.	23e. Did to	bacco use co	ontribute to	the cause of death?
S,	ires t sign									1 🗆 '	Yes 2. XIN	o 3 🗆 Pro	obably 4 🗆 Unknown
Vital Records,	v requ	Completed								24a. Was		lb. Were aut	opsy findings available
ခိုင	he lav te has age 2	mo.								autop perfo 1 Yes	rmed?	death?	ompletion of cause of
<u>=</u>	ian: T	Be C	25. Was case referred to medical examiner?				26. Pla	ace of Deat	th (Check o		Z LZINOJ	T L Tes	2 1NO
=	nysical	일	1 Yes 2X No	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 DOA Othe	er: 4 🗌 Nu	ursing Home	e 5 🗆 Resid	lence 6 🙀 C	Other (Specia	Assisted Living
0	ing Pl		27. Manner of Death 1	28a. Date (Mor	of injury oth, Day, Year)	28b. Time of injury	28c. Injury work	?		d. Describe h	ow injury occ	urred	DI VING-
õ	tend death tor; A the f	Certificate:	2 Accident Investig	not be				Yes 2 🗌					
JIVISION OT	l or A after Direc		4 Homicide determ	ined 266. Place build	ling, etc. (Specif	y)	et, factory, office		28	t. Location (S City or Tow		mber or Rura	al Route Number,
_	spita hours neral	Medical	29a. Certifier 1 Certifying	Physician: To the	best of my know	vledge, death o	ccured at the time,	, date and p	place, and o	due to the car	use(s) and ma	anner as stat	ied.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	(Check 2 Medical E only one) 3 Certifying	xaminer: On the ba Nurse Practioner:	sis of examination	on and/or invest	igation, in my opinic	n, death oc	ccurred at th	e time, date a	nd place, and	due to the ca	ause(s) and manner stated.
_	To To To		29b. Signature and title of certifier		N		29c. License		`	- 1	29d. Date sig		
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	Sp		30. Name and address of person Andrew Lazris,	L			rint) uite 103	Colu	mbia	MD 21	044		
	Stat Registra		31. Date filed (Month, Day, Year)	/ 32. F				COLU	шита	<u>21</u>	J 1 T		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ M9nth 20°TO Ann Pauline Rudder 2²4^y 10:34 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14269 Triadelphia Mill Rd. Dayton Howard 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 F Months Davs Min Country) 153-18-1451 107371921 88 Director Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗆 Yes 2 🖺 No MD Howard Dayton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 14269 Triadelphia Mill Rd. 21036 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than Homemaker Own Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salvador Carlucci Louise Dato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elayne Breton - Daughter 6116 Rippling Tide Terr. Clarksville, MD 21029 permit. Page 1 and 2 Department of Health Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🖾 Removal from State 4 Donation 5 Other (Specify) Israel Cemetery 7/30/10 Woodbridge, NJ 21. Signature of Funeral Service Dicense 22. Name and Address of FacilityHarry H. Witzke's Family F.H. Inc M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Opset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ mona disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 1110 signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? 2 1 No 1 Tyes Yes 25. Was case referred to medical examiner? Division of Vital funeral director. Be 26. Place of Death (Check only one) Hospital 2 No 1 Tyes 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred th. After 1 Natural 2 Accider 3 Suicide iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation fter dect 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Made

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	•			and Me	ntal Hyg	iene		
			State Registrar	Cer	tificate of D	eath		R	eg. No.	2010	21,875
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2	. Date of Deat Month	h Day	Year	3. Time of Death
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,	Examin	er	4a. Facility Nameriji not institution, give street and numberi		4b. City, Town, or		f Death			nty of Death	0.64
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last t	oirthday)	Batton If Under 1 Year	If Under 2		. Date of Birth		9, Birthp	lace (State or Foreign
	Director			Yrs.	Months Days	Hours	Min.	(Month, Day, oril 10,	Year) 1927	Count	maryland
	T 00 t		Usual Residence of Decedent 10a. State 10b. County 10c. City. To								
	ryland -f sh ied a	cto	, , , , , ,							[1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	r 28a notif	Director	Maryland Montgomery 5 10e. Street and Number	TTAG	Spring			T .	IOa Citizan a	of What Coun	
	vith th	ıral			Ton Zip codo	20910	1			USA	u y :
	eath v	Funeral	111.0 Fid1er Lane , Apt. 813 11. Marital Status 12. Was Decedent Ever in U.S.	13. V		_		Yes or No-		ace - America	an Indian,
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by F	1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates,		Yes, specify Cubar ☐ Yes 2 K No		Puerto Ric	an, etc.)	Speci	lack, White, e ify: Whi	
2-0	hour "natu dical	plet	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	ent's Usual Occupa ind of work done di	tion	of working		16b. Kind of	Business Inc	lustry
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Ż	d wit Hygie ther nt, th	Bec	12 A	amini	strative Se			Sund Addadds A			Labor
anc	ild be filed v Mental Hyy iarked oth atic event,	10 E	Joseph Clyde Raley					irst, Middle, N n C . Wo		me)	
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Σ	and 2 sh Health a tem 27 is other tra				Cherub Way,						,
e,	le 1 an t of He If item or othe				sition (Name of eatory or other place	,)	Date	e	20c. Locatio	n - City or To	wn, State
Ĕ	Page 1 ment of ant: If it ury or o		LA bullar 2 - Oremation 3 - Nemovarillom State	-	s Cemetery		July 30	, 2010	Ridge,	Maryla:	nd
Baltimore,	permit. Page Department o Important: If any injury or once.		21 Signature of Funeral Service Livernee Muchael Hardiner	22.	Name and Address	s of Facility	Mattir	ng1ey-Ga Box 270	rdiner Leonard	Funeral town, M	Home, P.A. 20650
П			23a. Part 1. Enter the disease) or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dying	, such as c	ardiac or re	spiratory arre	st,	1	Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	Back	retemin						Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence)	e of):							
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Box 6	e death certificate be executed the attending physician and shed for use as the burial-transifi	Physician/Me	23b. Was decedent pregnant in the past 12 montbe? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de Pregnant at time of deatt 9 Unknown 1 Unknown 1 Pregnant at time of deatt 1 Pregnant at time		Ectopic pregnancy Other (specify)	/				Date of delive Month	ry Day Year
0	v requires that the de been signed by the s should be detached	y P	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause give	en in Part I.		23e. Did tok	acco use co	ntribute to t h	e cause of death?
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<u> </u>	sian: ertifica ctor, I	Be	25. Was case referred to medical examiner?				n (Check on				
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SIO	Atten deat ctor: y the	ıţį.	2 Accident Investigation 3 Suicide 6 Could not be	farm, stre		res Z 🗆 I		Location (St	reet and Num	aber or Rural	Route Number,
Division of Vital Records,	al or / s after il Dire		4 Homicide determined building, etc. (Specify)		, , ,		201	City or Town		7,501 0. 71474	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifler 1	e, death o	ccured at the time,	date and p	lace, and d	ue to the caus	se(s) and mar	nner as state	d.
	the H hin 24 the Fi	Me	only one) 3 Certifying Nurse Practioner: To the best of my known		eath occurred at the	time, date a		and due to the	cause(s) and	manner as sta	ited.
_	vit So o		29b. Signature and tiple of certifier		29c. License		7 7	2	9d. Date sigr	ned (Month, E	Day, Year)
			1/7/11 MO	· /F	100	07	15		-((2	2((10)	
hug-			30. Name and address of person who completed cause of death (Item 23a) Cour Hort 22 5-			Bal	timo	1, 5	s av	2120	\
	Stat Registra	-	31. Date filed (Month, Day, Year) JUL 28 2010 32. July 28 3010	1	ald						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Junth Physician/ 9:30 AM Kichardson homas Medical a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fort Washington Medical Center Fort Washington Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day | June 20 9. Birthplace (State or Foreign Neuntry) Age (In yrs. last birthday) Funeral 1**火** M 2 □ F 71 245-64-7624 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should se filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director MD Prince George' 1 XYes 2 No Oxon Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Page 1 and 2 should : e filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is mar ed other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be rance. Funeral 1805 Fenwood Avenue 20745 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces , White, etc. Black þ 1 Never Married 2 Married Yes 2 No 1 🗆 Yes 2 🗖 No 21215-0036 Specify. If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Farmer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Golden Richardson Nick Artis Harper 19a Informant's Name/Relationship (Type, Print)
Shirley R. O Bannon/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 Fenwood Ave. Oxon Hill, MD. 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) Greater St Chapel Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/27/10 Enfield,NC 22. Name and Address of Facility Hillard Funeral Home 21. Signature of Funeral Service Licensee M1595 0206 North US 301 Whitakers, NC. 27891 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of _regnan_,
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death cate has been signed by the a page 2 should be detached by 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 X ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier the 29b. Signature and title of certifier 29c. License number 0 5 rson who. pleted cause of death (Item 23a) (Type, Print) BBM Hill Ratzon, Oxon Jatai Nazemian State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Reeder Lee 15:32 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington County Hagerstown Sex 1XXM 2 □ F Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Days Hours Min. Country) Mary Land Director 218-34-3686 72 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13710 Patriot Way 21740 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Page 1 and 2 should be filed within 72 hours after d ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or i þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Auto Mechanic (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Dealership other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian S. Wise Stanley Reeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie R. Reeder / Wife 13710 Patriot Way, Hagerstown, MD 21740 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park July 30,2010 Hagerstown, MD permit. Page 1 a Department of H Important: If ite any injury or ot 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, MD 23a. Part 1. Enter 1 e disease. In complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of if any leading to immedicause. Enter Underlying Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death as been signed by the 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗖 No Hospital 1 🗌 Yes ၉ 1 Mpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title D 38764 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO B- Monce 11111 127 21742 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

2010

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DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 27, 2010

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD

()4

COME

31. Date filed (Month, Day, Year)

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 2010 4:22a RAIMOND RICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Days Hours 1930 Maryland 79 **Director** 215-26-1349 Aug Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 4817 Round Hill Road United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 No 1948If Yes, Give 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. 1952 Specify: White 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Mail Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Mae Boller Eli Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 634 Wilson Place, Frederick, MD 21702 Karen Rotorick / Daughter Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Frederick, Maryland 7/26/2010 4 Donation 5 Other (Specify) Resthaven Memorial Stauffer Funeral Home 21. Signature Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Pat 1. Enter the disease of complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nerestetie Physician/ disease or condition 142 Medical resulting in death) Due to (or as a consequence of) Examiner hypote-1siv-Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (as a consequence of) The law requires that the death certificate be executed use as the burial-transi PEXIC and that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death the page 2 should be detached Unknown 9 🗆 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No 2 🗌 No 1 Tes within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, I or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Stat

Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

31. Date filed (Month, Day,

DCC 6 7691

7-71-10

Frederick, MD 21701

		For State Registrar	State o	f Marylar			nt of H re of D		nd M	lental H	ygien Reg. N	211	10	24881	
Physicia	n/	1. Decedent's Name (First, Middle, I	<u></u>		-					2. Date of D	eath		Year_	3. Time of Death	
Medic	edical CONNIE M. REED					4h City	Town or	Location of	Death	JULY	20	0 2	2010	11:18 PM	
Examin	er	35074 BLOSSON					ITTSV		Doutil		1	-	COMIC	0	
Funeral Director			i. Sex 1 □ M 2 X F	7. Age (In yrs. I		If Unde Months	r 1 Year Days	If Under 24 Hours		8. Date of B (Montb, E APRIL	irth Jay, Year) 6 , 1	957		place (State or Foreign try) CGINIA	
and show dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Loc	ation							1	0d. Inside City Limits	
Mary 28a-f	Funeral Director	MARYLAND WICOM	PITTS	_						1 ☐ Yes 2 🗓 N					
vith the	eral [10e. Street and Number 35074 BLOSSOM	СТ.			10t. Zij	218	50			10g. C	ng. Citizen of What Country? USA			
death v		11. Marital Status		dent Ever in U.	S. 13. V	Vas Dece	dent of His		n? (Spe	cify Yes or No)-		e - Americ		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, Giv Year or Da	2 X No e				Specify:				Specify:	k, White, WH	IITE	
172 hou an "nat Medica	Completed	15. Decedent' (Specify only highest	grade completed)	4 = 4 = 5 - 1			rk done d	ation <i>luring</i> most c	of worki	ng	16b.	Kind of Bu	usiness Ind	dustry	
ygiene ygiene her tha rt, the	o l	Elementary/Seconday (0-12)	College (1-	-4 or 5+)		CHE	?					RESTA		Τ	
be filec ental H ked ot ic even	To B	17. Father's Name (First, Middle, Las PETE M.		EED				18. Mother		e (First, Middle VE		n Sumame COMPT			
should and M is mar aumat		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Addres	s (Street a			l Route Numb				Code)	
and 2 Health em 27 ther tr		ALICE L. ELLIOT 20a. Method of Disposition	T/SISTER	20h F	9525 Place of Dispo			N CITY		Oate		IN, M			
Page 1 nent of ant: If iu ıry or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.	B ☐ Removal from ecify)	State	emetery, crem	natory or o	other place	ARVA 7			1			LAWARE	
permit. Departr Imports any inji		21. Signature of Funday Service 10	ensee					s of Facility	L HC	ME, SI	ELBY	VILLE	DE, DE	. 19975	
		23a. Part 1. Enter the disease, or conshock, or heart failure. List on	omplications that only one cause on ea	caused the deal	h. Do not ente	r the mod	de of d ying	g, such as ca	ardiac o	r respiratory a	arrest,			Approximate Interval Between	
Physician/ , Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myo	or as a consequence		NFA	nct	Nor						Onset and Death	
Examiner		CARDIOVASCULAR DISPASE													
ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury													
ate be executed ohysician and the burial-transi	l Exa	that initiated events resulting in death) Last Due to (or as a consequence of):													
cate be executed physician and s the burial-transit	edical		d												
aath certifica attending p for use as		IF FEMALE: 23b. Was decedent pregnant		come of pregna Birth 2 Feta	ancy	Ectopic	pregnancy					23d. Dat	te of delive	ery	
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	by Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		nant at time of		Other (s		у				Мо	nth	Day Year	
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached													ne cause of death?		
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ig Physter this	te: To	27. Manner of Death	28a. Date	Inpatient 2 of injury th, Day, Year)	28b. Time of injury		28c. Injury work	at		me 5 Res 28d. Describe)	
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e Hospi 24 hou e Funer	Medical	(Check 2 Medical Exa	Physician: To the base aminer: On the base Jurse Practioner:	is of examinatio	n and/or invest	igation, in	my opinio	n, death occ	urred at	the time, date	and plac	ce, and due	e to the ca	use(s) and manner stated	
To th withir To th comp	2	29b. Signature and title of certifier	_		, , ,		c. License	number			29d. D	ate signed	d (Month, i	Day, Year)	
500		30. Name and address of person wi	o completed cours	e of death /Item	n 23a\ /Tvne =	rint))68	700			Ju	ely ?	21,2	010 0 21811	
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Stat		31. Date filed (Month, Day, Year)	2010 32. B	egistrar's Signa	iture.	arka	1								

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ onth ORMO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Long View Nursing Home Manchester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min. OCT 25 215-32-5942 Director Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location notified at Director 28a-f PA York Glen Rock 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 7098 Simpson Road 17327 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. the Medical Examiner ö ģ 1 Never Married 2 Married ☐ Yes 2 X No hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Department of Health and Menta Important: If item 27 is marked , any injury or other traumations. 2 John Louis Jones Barbara H. Seiler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7098 Simpson_Rd. Glen Rock, Jean Conn - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 07/2^D3^t72010 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State South Carroll Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-t ansit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Completed has To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending 1 Tes 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier (Check Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier WIL

Myers-Durboraw Funeral Home , Westminster. Approximate Interval Between Whyet and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest charles, or heart failure. List only one cause on each line. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗌 No Yes 2 N Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed BALTIMORE, MD 30. Name and address of person who completed 2 cause of death (Item 23a) (Type, Print) MO NOU 31. Date filed (Month, Day, Year) 32. Re strar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

24882

3. Time of Death

255

9. Birthplace (State or Foreign

10d. Inside City Limits

1 🗆 Yes 2 🗶 No

Maryland

4c. County of Death

1934

Specify:

Own Home

PA

Winfield,

USA

Carroll

14. Race - American Indian.

White

17327

Black White etc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) ^D2010 **Physician** July 20, 1:50 p M Robert Melvin Stouter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Emmitsburg 7522 Friends Lane If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Maryland Months Days Hours Min 1**X** M 2□ F Yrs 73 1936 Jul 25. 219-36-4289 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Emmitsburg Director Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21727 7522 Friends Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. after 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No white Specify: <u>}</u> 3 ☐ Widowed 4 ☐ Divorced 72 hours Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pipe & Nipple permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If them 27 is marked other that afty Injury or other transmitted. Factory Worker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie Turner Melvin Francis Stouter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7522 Friends Lane, Emmitsburg, MD 21727 Frances Stouter, wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/23/2010 Emmitsburg, MD Friends Creek Cem 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 h /Medicai Due to (or as a N evauence of): Examiner 6 mon Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ပ this funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

310

L. CARROLL,

21

DHMH 17 Rev 1/2001

SOUTH SETON

32. Regetrar's Signature

29c. License number

AUE. EMMITSBURG, MD

29d. Date signed (Month, Day, Year)

21727

O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Veronica D. Simpson 22 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Encore At Turf Valley Howard Ellicott City If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/20/1959 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 50 086-52-9490 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at MD Howard Ellicott City Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 9800 Woodbridge Court 21042 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eonce. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vane Josephine Carello Joseph R. Destito 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9800 Woodbridge Court Ellicott City, MD 21042 Robert G. Simpson - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 07/28/2010 Clarksville, MD Columbia Mem. Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** etastat disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury within 24 hours after dearn.

To the Funeral Director: Af 1 ☐ Yes 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the 29b. Signature and title of certifier

10d. Inside City Limits

1 ☐ Yes 2 No

10 years

Year

Day

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra 24885 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 1845 M Howard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Hours Min. July 6, 1927 Country)
Washington D.C Director 578-30-9757 83 6, Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carrol1 Mt. Airy 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 6618 Jacks Court 21771 United States 'natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ۵ 1 Never Married 2 Married 72 hours after 2 No 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3

Widowed 4 □ Divorced Year or Dates. WWII Completed 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 4 / Designer Illustrator Commercial Art marked other Be Baltimore, Maryland Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! ပ John Connick Isabel Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 14510 Shirley Bohn Road, Mt. Airy, Maryland 21771 Hollis A. Smith / Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Michael's Cemetery 7/24/2010 Mt. Airy, Maryland 22. Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, 21. Signature of Futieral Service Ucense P. A. Frederick, Maryland 21771 23a. Part 1. Enter the disease, or complications the course the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ interio Myocardia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 1 No 1 Yes 2 No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifies within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 \square Pending 1 Natural 1 Yes Accident Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 66515 2010 Jal 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cawat 5575 Cedar Lane, Columbia, Maryland 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JUL

Box 68760

P.O.

Records,

of Vital

Division

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			For State Registrar		State of M	aryland /		ırtmer tificat			and ivi	_	Reg. N	0.0	In	21.00
	Physicia Medi		1. Decedent's Name	First, Middle, La	FAE	5	HUM	MAI	KE	R		2. Date of De Month	ath	av	Year	3. Time of Death
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920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Fur	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.					spanic Ori n, Mexicar Specify:		ify Yes or No- ican, etc.)			k, White	ican Indian, , etc. uite
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Baltimore,	nit. Page artment ortant: I injury o		4 Donation	5 Other (Spec	ify)		ffor	Cren	nator	у (/2010 Stau		deri		Marvland Home. PA
Ba	permit. Departr Imports any inji		21. Signature of Fu	6400 dr	blas		7	606	0 1 d	Natio	nal l	Pike Bo	oons			
	Physician/ Medical Examiner		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	Final	a. Due to (br as	d the death. D	o not enter	r the mod	le of dying	<u></u> .	cardiac or	respiratory ar	rest,		_	Approximate Interval Between Onset and Death
09	ate be executed obysician and the burial-transit	Completed by Physician/Medical Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated event: resulting in death) I	rlying iinjury s		a consequence a consequence		MCC.	MON	1100						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	nysician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	menths? No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal de	eath 3 🗔	Ectopic Other (s)		у				23d. Dat Mo	te of deli	very Day Year
ls, P.O.	uires that the signed by ald be detail	ed by Pł	Part II. Other signif	afer the	contributing to death to	out not resulting	ng in the un		cause giv		1.	23e. Did t		use contr	\/	the cause of death?
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Jo L	ding Physician: The la h. After this certificate ha funeral director, page	ate: T	27. Manner of Death	5 Pending	28a. Date of inju (Month, Da	ry 281	b. Time of injury	2	28c. Injury work	at	28	3d. Describe I				
Division	ial or Attences after death	Il Certificate:	2 Accident 3 Suicide 4 Homicide	Investigatio 6 Could not I determined	De Place of Ini	ury - At home, c. (Specify)	, farm, stree	M et, factor		Yes 2 L		8f. Location (City or Tov			∍r or Rura	al Route Number,
	Hospit 24 hour Funeral leted fill	Medical	(Check 2	Medical Exam	vsician: To the best of niner: On the basis of e ree Practioner: To the	examination an	d/or investi	gation, in	my opinic	n, death or	ccurred at t	he time, date a	and plac	e, and due	e to the c	ause(s) and manner stat
	To the vithin To the comp	N	29b. Signature and		Jan M		owioage, at	290	c. License		1	, and dde to ti		- 1		gay, Year)
04	H-4		30. Name and address	ess of person who	completed cause of	leath Item 23	a) (Type, Pr	-	051	relar	1 4	Total I	HAZ	Sol	Inst	MA
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	Registr	ar	`		VIV LAS		. 600	ON CHANGE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201⁸0° July 21^{ay} 4:00 Рм Lelon C. Sowell, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6/22/1920 Director 413-28-2139 90 Marshall Cty, TN Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Eart, If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Seat Pleasant 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6111 Addison Road 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baker Marriott Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James A. Garfield Sowell Minnie Mayberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Sowell (wife) 6111 Addison Road Seat Pleasant, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Fort Lincoln Cemetery 7/31/2010 permit. Page 1
Department of Important; If it any injury or o once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of Fundamental Licensee 3401 Bladensburg Road Brentwood, MD 20722 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Float Physician. disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): [•]Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dysphagia 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo မ 1 K Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0063195 7/23/2010 S. Wilks 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road Steven Wilks, MD Bethesda, MD 20814

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 4:16 PM Thomas Forbes Smith Jul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Regional Hospital Prince George's aurel aure 6 Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Hours (Month, Day, Year) 2/7/1923 Salisbury. Director 216-16-0571 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified 1 X Yes 2 No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 14200 Laurel Park Drive 20707 items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify 3 X Widowed 4 Divorced White er than "natur the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 3 Television Repairman Service Repair Company is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Roy Smith Mary Forbes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20815 27 Harold Grainger / Friend 8401 Connecticut Avenue, Suite 105, Chevy Chase, MD Department of Health Important: If item 2; any injury or other tonce. injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 7/28/10 Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue han wood Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death
MUTES shock, or heart failure. List only one cause on each line Immediate Cause (Final Infarction Physician/ Acute Myocardial disease or condition resulting in death) Medical **Examiner** Cardiovascular Atherosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner Diabetes physician and the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events vedvs resulting in death) Last Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 4 Pregnant Pregnant at time of death ate has been signed by the apage 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cerebrovascular Disease 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an autopsy Renal Insufficiency performed Yes 2 1 🗌 Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 aure, Wang Koon, Regiona aure Hospita

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 7 2010

32. Registry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July Physician/ 2010 12:55 Phyllis Jean Thomas Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Hospice House of St. Mary's Callaway 8. Date of Birth (Month, Day, Year) 01/24/1933 5. Social Security Number 6. Sex if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 □ M 2XXF Months Days Hours Min. 210-24-6249 Director Pennsvlvania Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director St. Mary's Dameron 1 Yes 2XNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Jerome's Neck Road 20628 USA 18644 St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural". ... any injury or other traumatic event. 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 K Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Esther Montgomery Arthur Stroup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 88, Valley Lee, MD 20692 Steven Thomas/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 07/24/2010 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, Brinsfield-Echols Signature of uneral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 019 disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions, Examiner cause (Disease or linjury that initiated events Due to forme a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) <u>Hospice</u> Hospital 2 No Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Director After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and addre

31. Date filed (Month, Day

Jennifer Schmidt,

27

40900 Merchants La., Leonardtown, MD 20650

of person who completed cause of death (Item 23a) (Type, Print)

D.O.

32. R

DHMH 17 Rev 7/2009

P.O. Box 68760

Division of Vital Records,

P.O. Division of Vital Records,

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 1 2010

Maiden

32. Redistrar's Signature

29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day **EDITH** MAY THAXTON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DOCTORS COMMUNITY HOSPITAL PRINCE GEORGES LANHAM 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F JUNE 25, 1932 Country) Director 78 PA 170-26-7373 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No MD PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 13524 NEW ACADIA LANE 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 XYes 2 ☐ No. If Yes, Give 1950<u>–</u> 1954 1 Yes 2 No Specify. Specify. 3 🛣 Widowed 4 □ Divorced Year or Dates BLACK other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within SURGICAL NURSE MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM Η. JACKSON SR. LAURA F. **BROOKS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1390 SANTA ALICIA AVE.#11107, CHULA VISTA, CA.91913 AARON D. THAXTON/SON Baltimore, Department of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State any injury or 7-23-2010 4 Donation 5 Other (Specify) CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SHOCK Immediate Cause (Final EPT Physician/ disease or condition resulting in death) Medical RESPIRATORY FAILURE Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ANEMIA To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and perpendicted filled in by the funeral director, page 2 should be detached for use as the buriar-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical ARRHYTHMIA ARDIAC Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🛮 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Acciden ☐ Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANDRASEKHAR KORAPATI, 7207 HANOVER PWY# B. GREENBELT 20770 31. Date filed (Month, Day, Year)

2 6 2010

Chandselle Kayet - MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MD52855

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24892 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ora Belle Tamm 07/23/2010 5:35 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/16/1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛣 F Georgia 88 Director 428-16-0201 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modern Extramonal routher and MD Montgomery Gaithersburg 1 ☐∀es 2 ☐ No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20877 301 Russell Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**K** No Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maude Thomas ပ္ Marvin Phillips 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Quinn John Tamm / Son 409 54th Street Virginia Beach, VA 23451 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 17/25/10 Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Par 1. Enter the disease, or complications the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 8 ma /Medical Due to (or as a consequend Examiner Sequentially list conditions, it any leading to it is a distributed ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of): Examiner P.O. Box 68760, Co. or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Physician/Medical director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? yes 2,⊠No 2)ENo 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 2 XX Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State

Registrar

30. Name and address of person who completed cause of death

26 2010

Ndidi Feinberg 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

1st Fl. Mamotsville MA

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 19 Day 2010 Year Physician/ John Edgar Wyatt 0709 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll 629 Littlestown Pike Westminster 5. Social Security Number 8. Date of Birth (Month, Day, Sep 17 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1<u>949</u> Months Hours 1 X M 2 🗆 F 212-52-4596 60 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Carroll Westminster 1 ☐ Yes 2 X No Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21157 629 Littlestown Pike USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify white Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Co Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Annie Jones John Wyatt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 733 Johann Drive, Westminster, MD 21158 John Wyatt, son 20a. Method of Disposition 20b. Place of Disposition (Name of central transfer place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/20/2010 Winfield, MD Carroll Crematory Myers-Durboraw Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility 91 Willis Street, Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Probable acute myocardi minutes disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed nding physician and use as the burial-transil that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Street at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate 2 No 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) WJ Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryland		rtment of F tificate of D		ental Hygier Reg.	2010	24895
Physicia	n/	Decedent's Name (First, Middle, Last)	9				2. Date of Death	Day 2 2 Year	3. Time of Death
Medic Examin	al er	Benjamin Frank 4a. Facility Name (if not institution, give str	eet and number)	son, J		Location of Death	July	4c. County of Dea	th
		Peninsula Regiona 5. Social Security Number 6. Sex	1 Modical (cntc	If Under 1 Year	alisbur If Under 24 Hrs.	8. Date of Birth	Wica	the loss (Carte ou Fourier
Funeral Director		214-32-7676	M 2 □ F 77	Yrs.	Months Days	Hours Min.	(Month, Day, Yea 03/12/19	33	untry) Maryland
and show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
e Maryl r 28a-f notifie	Director	Maryland Wicomico)	Shar	ptown 10f. Zip Code		10-	Citizen of What Co	1 🗌 Yes 2 🔼 No
with th s 23a o ust be	Funeral	103 Reid Street				861	Tog.	U S A	Junta y r
pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of H	by Fur	11. Marital Status 12 Married 12 Married 12	. Was Decedent Ever in U.S Armed Forces? 1 ☒ Yes 2 ☐ No	If	as Decedent of His Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto P	eify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
nours after latural", o	Completed	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ		57 - L+5 - 15	ent's Usual Occupa		166	Specify:	White Industry
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d 2 sho alth and 27 Is I		19a. Informant's Name/Relationship (Type Nina J. Wilkerson	·			nd Number or Rural • Sharpto			o Code)
ge 1 an tof He :: If iten or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re		ace of Dispos	atory or other place	e) i	1	. Location - City or	
partition Page 1 Department of Important: If it any injury or of once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service License	0.1	Chur 22.	Ch Cemet Name and Addres	ery July s of FacilityBrin	<u>28,201D</u> sfield-Ec	Newport, hols Fun	MD eral Home,P.A
		23a. Part 1. Enter the disease, or complic	etion that called the death					otte Hal	Approximate
Pnysician.		shock, or heart failure. List only one illimmediate Cause (Final disease or condition	cause on each line.	. C	- Lange or aying	e po the	respirately allowing		Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consequence	ence of):	0 1	Diva	st.		4
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):	1 da brond	17,000			1.2001
cate be executed physician and sthe burial-transit	Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a consequent	ence of):					
ate be e	edical	d.							
certifica ending p	₹	200. Was decedent pregnant	If yes, outcome of pregnar □ Live Birth 2 □ Fetal	ncy	Estanic pregnanc			23d. Date of de	livery
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the aftending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown		Other (specify)	,		Month	Day Year
is that the igned by be deta	þ	Part II. Other significant conditions control	ibuting to death but not resu	ulting in the un	derlying cause giv	en in Part I.			the cause of death?
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The lav	Com	y per reported					autopsy performed 1 🗆 Yes 2 🏿	? death?	completion of cause of
s certifications	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	FR/Outpatient	Otho	er: 4 Nursing Hon	only one) ne 5 Residence	6 Other (Spec	nifv)
ling Phy 1. After thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		28b. Time of injury	28c. Injury work	at 2	8d. Describe how in		
r Attencter deat	Certificate:	2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				28f. Location (Street City or Town, St		ral Route Number,
spital o	ical C	29a. Certifier 1 Certifying Physici	an: To the best of my knowle		ccured at the time,	date and place, and			ated.
the Ho thin 24 h the Ful mpletec	Medical	only one) 3 Certifying Nurse	: On the basis of examination Practioner: To the best of my		eath occurred at the	time, date and place	, and due to the cau	se(s) and manner as	stated.
or wit		29b. Signature and title of pertifier	Bankern	is.	29c. License	L~//	_ ~	Date signed (Mont	7.016
-		30. Name and address of person who com	1 1.1	23a) (Type, Pr	int)	ALLE SI	6 my ford	5- (11	my A16 2/804
Stat		31. Date filed (Monty Uty, 1218 201	32 Registrar's Signatu	1. Ja		THE 7	11 re 6/15	Zhrych	my 110 41504
Registra	ar		1	- 140					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:04 p Physician/ Year July 24, 2010 Eileen Corr Williams Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number Year If Under 24 Hrs. If Under 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Day, Yea, 1914 July 1 Days Hours Min Coun 1 □ M 2 🕱 F Months itry) Yrs **Director** 060-01-0082 96 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Mon topmery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2913 Peregoy Drive 20895 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 X Married Yes 2 XNC If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Homemaker Own Home traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e once. John Corr Rose McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Bier Williams/Husband 2913 Peregoy Drive, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of July 2010 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 21 Cremation 3 Removal from State Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) Signat e of Funeral Service Dicense Name and Address of Facility rancis J. Collins Funeral Home Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring MD 20901 Molin 23a. Part 1. Enter the disease, or complict tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Acute Cerebrovascular Accident Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Coronary Artery Disease Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? Day Month Year Yes 2 🙀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 2 🗓 No 1 Tes Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 2 X No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

attending physician and for use as the burial-transit executed Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the signed by has certificate director, e Funeral Director: After this

28a-f shov

should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a مه 9aa-f مامي

Baltimore, Maryland 21215-0036

မ Certificate: Medical

27. Manner of Death

Natural
Accident
Suicide

4 Homicide

Dr. Delroy Anglin

29a. Certifier

5 Pending

Investigation 6 Could not be

determined

To the within 2. 10

(Check 2 Medical Examiner: On the basis of examination and/or investigation by unit) A Certifying Number Practioner: To the basis of examination and/or investigation		
9b. Signature and fine of certifier	29c. License number D55149	29d. Date signed (Month, Day, Year) July 24, 2010
C. Name and advance of parameters and advance of death (flows 20c) (Time Drink)		

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work 1 Tyes

2 🗆 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

28a. Date of injury (Month, Day, Year)

1500 Forest Glen Road, Silver Spring, MD 20910

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}010 July Wheeler 12:20 p M Clara 16, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** 1 □ M 2 🕅 F Months Days Min. 050-28-2009 Yrs. 03-30-1934 South Carolina Director 76 Usual Residence of Decedent show Bajtimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 X Yes 2 □ No DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20010 1489 Newton St. N.W. #66 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. Completed by 1 🕅 Never Married 2 🗌 Married 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Visiting Nurses Assoc Home Health Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Phyllis Cambino James Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1489 Newton St. N.W. Washington, DC 20010 Kama Wheeler (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 07/21/2010 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th St. N.W. Washington DC 20010 CC0518 23a. Part 1. Enter the disease, or comilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Probable breast cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Severe cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been executed to the control of the control inding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 1 Yes 2 L 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 2X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 📉 Other: Certificate: To 1 K Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After in pleted filled in by the funera 1 🛚 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I

State Registrar

2

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

JUL

Yeheyis Negussie

26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

37. Registrar's Signature

D45471

1500 Forest Glen Road Silver Spring, Maryland 20917

29d. Date signed (Month, Day, Year)

07-18-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death Physician/ A M 2010 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KEDIONAL HICOMICO SALISHIA 1 Year If Under 9. Birthplace (State or Foreign 6. Sex If Under Social Security Number 8. Date of Birth Sex (7. Age (In vrs. last birthday) **Funeral** Months Days (Month, Day, 63 Director ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2180 . Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ₩Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18_Mother's Name (First, Middle, Maiden Surname) မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughotes 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 3 Other (Specify) 21. Signature of Fineral Service License 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Pneumenia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner End stage renal Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Diabetes Mellitus and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 for use as IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death as been signed by the 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has I funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ျှ 1 🗌 Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifie

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 €.

Registrar's Signatu

29c. License number

068222

SALISBURY

29d. Date signed (Month, Day, Year)

07-23-10

10-05785		Please Type or Print in Black Indelible Ink. Ensure All Cop		gible.	
Anthony Edwar	d W	otato of mary population of reality and morning	Hygiene	201	2100
		1- For State Registrar Certificate of Death	F	Reg. No.	2489
Physic	ian/		2. Date of Dea	ath	3. Time of Death
Medical Exam	iner	ANTHONY EDWARD WILLIAMSON	Month August 1	Day Year 2010	2115 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dec	ath	4c. County of Deat	1
		Prince George's Hospital Center Cheverly		Prince George	e's
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24h	Irs. 8. Date of B	rth(MM/DD/YYYY) 9. Bir	
Director		542-96-6252 1×M 2 F 39 Yrs. Months Days Hours N	fin. FEB.	20, 1971 Foreign	on ountry) ARKANSAS
		Usual Residence of Decedent			
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
*	_	VIRGINIA FAIRFAX ALEXANDRIA			1 Yes 2 X No
urylar Sa-f s	Director	10e. Street and Number 10f. Zip Code	T	10g. Citizen of What Cou	Intry?
or 23)ire	1831 DUFFIELD LANE 22307		U.S.A.	
death with the Maryland or items 23a or 28a-f show must be notified at once.	<u> </u>		Specify Yes or No	14 Race - Amer	ican Indian, Black,
ath v item:	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puer		White, etc.	, D. G. G.
ter de	J.			Specify: WHI	TE
15-0036 filed within 72 hours after death with the Maryland I Hygenen ed other than "natural", or items 23a or 28a-f she t, the Medical Examiner must be notified at once	l b	To Dates:	of work done	16b. Kind of Business/	
2 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use re	etired)		
336 thin 7 than than	Completed	12 RIDE CAPTIAN		PATRIOT G	IIARD
d will	5	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	ne (First, Middle,	Maiden Surname)	OTTIO
215 oe file ntal H ked o	Be (OYCE WIL	LIAMSON	
21 Duld b	ᇋ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	r Rural Route Nu	mber, City or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		JENNIFER J. ROBERTS - WIFE 1831 DUFFIELD LANE,	ALEXANDR	IA, VA 2230	7
e, lead I and Heal Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
nor ages at the other		NATIONAL CREMATORY 8/	6/2010	FALLS CHUR	CH, VA
Itin lit. P artme ortar		4 Donation 5 Other Specify:		NERAL HOME	
Ba Per The Tinju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility DE 520 S. WASHINGTON	STREET,	ALEXANDRIA	, VA 22314
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a Multiple injuries			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b			
	ner	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or Lighty that inflated Levents resulting in death. Last Due to (or as a consequence of):			
الله الله الله الله الله الله الله الله	X	events resulting in death) Last Due to (or as a consequence of): d.			
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	cal		200		
30, te be ysicia	ledi	25a,27,26a-1,per HE g500 0710710	I'I'	23d, Date of deliver	
876 tifical tig ph	ian/M	23b. Was decedent pregnant in the 1 Live high	nancy)ay Year
× 6 h cer tendi	icia	4 Pregnant at time of death 5 Other (Specify)			,,
Bo e dear the au	hysici	1 Yes 2 No 9 Unknown 9 Unknown			1
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be reform. After this certificate has been signed by the attending physici by the funeral director, page 2 should be deached for use as the bun	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
sign.			1Ye:	s 2 🗸 No 3 Prot	ably 4 Unknown
rds requ	ompleted		24a. Was autor		topsy findings available ompletion of cause of
e law te has	E G			rmed? death?	_
F P III III III III III III III III III	ပ	25. Was case referred to medical 26.Place of Death (Chec		2 10 10	3 2 110
irecto	Be	examiner? Hospital: A Inneticet 2 FB/Outpeticet 3 DOA Other; Nurse	sing Home 5	Residence 6 Other	
n of V ling Phy After th	<u>1</u>	1 Ves 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?			
nding th.	ertification:	1 Natural 5 Ponding (Month, Day, Year)	motorcy	how injury occurred op cle struck ejected	guardrail
Division tal or Attendir rs after death. al Director: A	cat	2 Accident Investigation 8/1/10 8:30 pm 28e Place of Injury - 4t home farm street, factory office building etc.			ral Route Number City
Divi	rtif	determined (Specific) roadway	or Town, S	Street and Number of Ru State) SB I-95 College Pa	@ 1-495 rk. MD
ospi hou uner	ပ	29a. Certifier			
the F	ica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To T	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Moi	nth, Day, Year)
	-	O.C.M.E.		August 2, 2010	
		Foto Un- Tollin			
$\langle \! \! \! \! \! \! \! \! \! \! \! \! \! \! \! \! \! \! \!$		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore MD 2120	1	
	ote.		, 2120	·	
Regis	tate trar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#18perfState-afl Many 870 / Department of Health and Mental Hygiene 24900 State Registrar Amend#1perphys7/28/2010ccdof**@httificate of Death** Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Barny Barr Yingling Physician/ Day Year David Medical 2010 : 40 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Randallston Baltimore Seasons Hospice Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 □**X**M 2 □ F Months Days Hours Min **Director** June -4617 ral", or items 23a or 28a-f show Examiner must be notified at Charles 10c. City Town or Location LaPlata within 72 hours after death with the Maryland 10d. Inside City Limits Director 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10102 Charles Street USA 20646 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifyWhite "natural", 3 Widowed 4 Divorced Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 11th College (1-4 or 5+) Septic Tank Service Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank C. Yingling Sr. Mary Dorothy Ryan Bryan 19a. Informant's Name/Relationship (Type, Print)
Dale M. Yingling/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10102 Charles Street LaPlata, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Trinity Memorial
Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/26/10 Waldorf,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Brisce-Tonic Funeral Home M1595 2294 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ las unosch disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Disense Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ours after death.

eral Director; After this certificate hilled in by the funeral director, page 2 No 1 Yes Yes 2 110 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 6 Wother Specify lospital Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Acciden
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical

BBU State

6

29a. Certifier (Check

KHION

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar

verson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SUITE ZO3

29d. Date signed (Month, Day, Year)

2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

tacks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25perME, G907, 9/14/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Yea ATHYLZAMOSTNY 2:26 PM JULY 7 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTS BALTIMORE Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 30, 1951 g. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Months Hours Director 290-50-0258 59 Chio Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2 No Maryland Mon topomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 1409 Red Oak Drive 20910 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Psychologist Psychology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev James Edward Patz Erith Wainer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas James Zamostny/Husband 1409 Red Oak Drive, Silver Spring, MD 20910 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan Crematory 1 Burial 2 K Cremation 3 Removal from State July Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses 2frame and Address 15th Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition -NTRACRANIAL HEMORRHAG Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any leading to in medicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Dilli to for as a consectioned of APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and pempleted filled in by the funeral director, page 2 should be detached for use as the funeral control of the funeral director. Due to (or as a consequence of) CERTIFICATIO 10√ 10 M EDIVISION Of VItal Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ □ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 MInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Matural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗌 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) MI AU4176435B100552 JULY 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

HRISTOPHER

filed (Month, Day, Year)

2 6 2010

BROWN

2

2. Registrar's Signature

GREENEST SUITE SIZD BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#3perPHYS, G906, 8/17/2010, WS
State of Maryland / Department of Health and Mental Hygiene 24902 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary L. Archibald 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Chesapeake Anne Arundel Arnold 8. Date of Birth (Month, Day, Year) Oct 6, 1933 Social Security Number 7. Age (In yrs, last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Days Hours Min. Mary Land 214-30-5159 Director 76 Usual Besidence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No Glen Burnie Maryland Anne Arundel 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral **USA** 21061 7975 Crain Highway Unit #313 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Media (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Hospital Admitting Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice S. Hampton Geraldine Freed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7922 Crain Highway Glen Burnie, Maryland 21061 Colleen T. Ridler, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/09/10 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Liver ee Thomas Gregor emation Society Of Maryland, Inc. 99 Frederick Road Baltimore, Maryland 21228 Komsu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due la (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death Meck only one) Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hwy Millersville MD $\mathcal{I}_{\mathcal{I}}$ 31. Date filed (Month, Day, Year) Registrar

10-05903	-:	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Candace Argena		State of Maryland / Department of Health and Mental Hygiene 2010 24903 1-For State Certificate of Death
		Registrar Neg. No.
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Candace Argenziano 2. Date of Death Month Day Year August 6, 2010 1734 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Elkton Cecil
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		143-40-7200 1 M 2 F 61 Yrs. Months Days Hours Min. Feb 3, 1949 Foreign Country) Hawaii
ų		Usual Residence of Decedent 10a, State
d now ar		Maryland Cecil Elkton 1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
the M a or 2 tiffed	Pig	93 Pleasant Hill Drive 21921 USA
with ms 23	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
r death or ite must	F	1 Yes 2 No
rs afte	ē	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify. Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
2 hour	ted	Elementary/Secondary (0-12) College (1-4 or 5+)
D36 thin 7 ne.	Completed	12 Teacher Public Education
5-0 led wi Hygie other		17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)
121 d be fi lental j arked	Be	Richard Hall Joan Hughes
D 2 shoul and M	리	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neil Argenziano, Husband 93 Pleasant Hill Drive Elkton, Maryland 21921
and 2 lealth tem 2 traun		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumantic event, the Medica		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metro Crematory Inc. 08/09/10 Baltimore, Maryland
Iltin nit. Pa artmen ortan ry or		4 Donation 5 Other Specify: Metro Crematory Inc. 08/09/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 23.23.29
Dep Dep Inju	H	21. Signature of Funeral Service Icensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part I. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart Approximate Interval Parkage of the death of the dea
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Morphine and Oxycodone Intoxication
		or condition resulting in death) Due to (or as a consequence of):
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in (leath) Last Due to (or as a consequence of):
nted d ansit	EX	events resulting in death) Last Due to (or as a consequence or): d.
Box 68760, e death certificate be executed the attending physician and red for use as the burial - transit	dical	■ UNPENDED □ AMENDED 23a,27,28a-f per me g906 8-17-10 vt
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
x 68 h certi ending use as	ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
BO)	hys	1 Yes 2 No 9 V Unknown 9 Unknown
Division of Vital Records, P.O. B To the Hospiral or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
IS, F quires en sign	fed	24a. Was an 24b. Were autopsy findings available
cord law red has be	Completed	autopsy prior to completion of cause of performed? death?
Rec The ficate , page	딍	1 Yes 2 No 1 Yes 2 No
ician: s certi	a	25. Was case referred to medical examiner? 1 Was 2 No Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other:
of V g Phys ter thi	은	1 V Yes 2 No 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred
OD C ending ath.	틶	1 Natural 5 Pending 8-6-10 4:30 pm 1 Yes 2 x No unknown
VISI or Att fter de Directe in by t	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Dital o	le T	4 Homicide (Specify) residence 193 Pleasant Hill Rd. Elkton.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 7, 2010
ord		Miller Mashely 110
4 pera		30. Name and address of person who complited cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St	ate	M. Davidski, M. D. V. A. Borinski, Grands
Regist		AUG 1 0 2010 August 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 Per FH G906 8/11/2010 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24904 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ekanc PM 2010 Medical 4a. Facility Name (if not institution Examiner Town, or Location of Death 4c. County of Death Baltimore Medical enter HIMO Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** If Unde 1 Year M 2 🗆 F Days July 26, 1944 **Director** 5064 44 66 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1511 E. Chase St. 21213 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 | X Yes 2 | NoNavy
If Yes, Given
Year or Datas 0 / 63 - 5 / 66 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cable Installer Comcast yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Charles Alexander Rosa Lee Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
er) 2655 Wilkins Ave. Balto, Md. 21223 Brandi K. Alexander(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State .9,2010 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from Green Mount Crematory ☑ Donation 5 ☐ Other (Specify) Balto.Md ignature of Funeral Service Licensee 22. Name, and Address of Facility
Calvin B. Scruggs Funeral Home
1412 E. Preston St. Balto, Md. Preston St the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that cause Approximate Interval Between shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final Physician/ percapnerc ofraton disease or condition resulting in death) month Medical Examiner ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the huneral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by RUE DVT, HTN, DMI Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 🗌 Yes 2 No 2 \ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 🗆 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 1083866834 va 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seng Greene Street, Baltimore, MD MO arol 11 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2010 2:15A Raymond Barnes Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchey Hospice Ctn. Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F (Month, Day, Year) 03-03-5 Director 214-56-6397 60 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA XYes 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5112 Oaklawn Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African "natural", or 1XXNever Married 2 ☐ Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12)
7th Grade College (1-4 or 5+) Forest Heights Apt. Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o Lawrence В. Barnes Pearl Louise 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 1503 N. Ellamont Street Baltimore, Delores C. Barnes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date Page 1 1 X Burial 2 Cremation 3 Removal from State any injury or Cathedral Cem 08-11-10 New Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Address of Facility Wylie Funeral Home Gilmor Street Baltimore, MD 638 N. 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NOW SMALL disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be CENES IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? METASTASES Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown BLAIN METHATASES 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Y Other (Spec Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

102010

	For State Registrar	State of Mary		rtificate of De	eath	Re	eg. No. UIU	24906	
cian lical	1. Decedent's Name (First, Middle, La Patricia	nst)	Brown			2. Date of Death Month August	Day Year	3. Time of Death 7:00 P N	
iner I	5. Social Security Number 6. 8 217-34-9174	thpoint	n yrs. last birthday) Yrs.		t Under 24 Hrs. 8	B. Date of Birth (Month, Day, Nov • 23	Year) Cou		
_	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits	
Director	Maryland N/A		Baltim					t√XYes 2 □ No	
	10e. Street and Number 6910 Bank Stree	· t		10f. Zip Code		10	Dg. Citizen of What Cou	untry?	
Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Eve Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Y} \) No	r in U.S. 13.	21224 Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto Ri	ify Yes or No- ican, etc.)	U.S.A. 14. Race - Amer Black, White		
b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	16a. Dece	dent's Usual Occupation	Specify:	F 1	Specify: WI 16b. Kind of Business/I	nite ndustry	
Completed	(Specify only highest gr. Elementary/Secondary (0-12) 12th. Grade	College (1-4or 5+)	1	kind of work done dur DO NOT use retired) emaker	ing most of working		Own Home	2	
Be C	17. Father's Name (First, Middle, Last	1)		18	3. Mother's Name (First, Middle, N	faiden Surname)		
TO E	Albert		Hollan	đ	Leona		Fal	oaczak	
	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street and	d Number or Rural	Route Number,	City or Town, State, Z	ip Code)	
	Paul Brown/Son			0 Bank Str		ltimore			
	20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	J Removal from State		sition (Name of natory or other place) Crematory	8/11/20		20c. Location - City or 1 Glen Burnie		
	21. Signature of Juneral Service Lice	nsee	22	Name and Address Charles 6224 Fas	S. Zeiler tern Aver		, Inc. 1timore MD	21224	
	23a. Part 1. Enter the Isea: or conshock, or heart fall we. List only Immediate Cause (File disease or condition resulting in death)	_	ROTHELI			respiratory arre	est,	Approximate Interval Between Onset and Death	
edical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	,						
Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of delivery Month Day Year	
þ	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause given	in Part I.	23e. Did tob	eacco use contribute to		
Completed						24a. Was ar autops perform	y prior to d	topsy findings available completion of cause of	
Be C	25. Was case referred to medical examiner?			2	6. Place of Death				
P L	1 ☐ Yes 2 ☑ No		2 ER/Outpatier			e 5 🗌 Reside	ence 6 Other (Spec	cify)	
Certification:	27. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		ear) 28b. Time of Injury	Work?	t 28 s 2 □No	3d. Describe ho	w injury occurred		
Certifi	3 ☐ Suicide 6 ☐ Could not be determined		At home, farm, str Specify)	eet, tactory, office	28	3f. Location (Sti City or Town	reet and Number or Ru n, State)	ral Route Number,	
Medical		hysician: To the best of m miner: On the basis of ex and manner stated	amination and/or in						
Ž	29b. Signature and title of certifier	The		29c. License n	umber 60560		9d. Date signed (Month	261 O	
tate trar	30. Name and address of person who PANWF KHETET 31. Date filed (Month, Day, Year) AUG 102010		PHILAD	Print) ELPIHA P		08, B	ALTIMORE	s IND.	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 24907 Certificate of Death Rea, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 5:Ai 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 805 Cedarcroft Road Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 👿 F 218-03-6818 96 Months Hours Yea Director Mary Land shov within 72 hours after death with the Maryland 10a, State 10h. County notified at 10c, City, Town or Location Director 10d. Inside City Limits 28a-f 1X Yes 2 ☐ No Maryland N/ABaltimore 10e, Street and Number items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 805 Cedarcroft Road 21212 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian, Armed Forces ō þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural" Completed 3 X Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Railroad <u>Stenographer</u> Be traumatic event. 17. Father's Name (First, Middle, Last) and Mental F 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဨ Joseph Alexander Fecher Anna Theresa Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Boone Stolba (daughter) 805 Cedarcroft Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 8-10-10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility Lichell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 erun 23a. Part 1. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death 5 E TI Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a conseque The law requires that the death certificate be executed Due to (or as a consequence of): g physician arest physician are the burial-t resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant Pregnant at time of death Month Day 1 Yes 2 No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Yes 2 No or Attending Physician: 25. Was case referred to examiner? Be 26. Place of Death (Check only one) Hospital: 2 - No 1 Yes Other: ၉ 1 🗌 Inpatient 2 🗌 ER/Outpatient 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniun work' Accident Suicide filled in by the Investigation М 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

State Registrar FERNAN JO

AUG 1 0 2010

31. Date filed (Month, Day,

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705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3/17/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Agnes S. Berz August 1:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Oak Crest 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min 11^MO4/1^{*}922 220-14-3402 Baftimore, MD **Director** 87 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Baltimore 10e. Street and Numbe 6 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral U.S.A. 21234 8832 Walther Blvd. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Clerical is marked other Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Isabelle M. Trageser Joseph H. Holtman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 Shefford Road, Baltimore, MD 21239 Isabelle Trainor/ sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 08/14/2010 Dulaney Valley Mem. Timonium, MD 21. Signature of Full Line Lice 22. Name and Address of Facility Towson, MD 21204
Ruck Towson Funeral Home, Inc. 1050 York Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Disease alzheimers disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 24 hours after death. Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' Division 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours.

To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioners To the best of my Rhowledge, death occurred at the fire and title of certifier 29d. Date signed (Month, Day, Year) R171944 titeally 9 2010

State Registrar 30. Name and address of perso

Walther Blad, Parkvelle, MD 21234

oleted cause of death (Item 23a) (Type, Print)

CRNP MSH

8800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2010 Month Physician/ Robert Athearn Berrien 10:43 P M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 **X** M 2 □ F Hours 04/3/192 485-14-0435 87 **Director** Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2 X No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Completed by Funeral 20877 USA 419 Russell Avenue, Apartment #118 12. Was Decedent Ever in U.S.
Armed Forces?
1 🖾 Yes 2 🗆 No 7/1/43 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 No 7/1/43
If Yes, Give Year or Dates to 4/21/59 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 K No Specify. Specify: Caucasian 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Lawyer Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ٩ Harry George Berrien Rita Athern 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5351 St. James Place, Frederick, MD 21703 Kathleen B. Cunningham, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory, or other place Funeral Choices of Chantilly 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗌 Burial 2 🔀 Cremation 3 🗎 Removal from State 8/12/2010 Chantilly, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Choices of Chantilly 14522L Lee Road, Chantilly, Virginia 20151 Dary CC0508 bunen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiac arrythmin Priysician/ Medical Due to (or as a consequence of): **Examiner** ocupe it ally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed use as the buriaf-transi that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month for Year Day ed by the a detached f 1 Yes 2 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 2 prior to completion of cause of death? page 2 certificate has 1 ☐ Yes 2 ☐ No director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 🗌 Yes 2 🔲 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number #62580 August 6, 2010

State Registrar

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BERRIEN

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Germantown, Maryland 20874

30. Name and address offerson who completed cause of death (Item 23a) (Type, Print)

#130,

20251 Century Blvd.,

31. Date filed (Month, Day, Year) AUG 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G906 8/10/2010 Jh State of Maryland / Department of Health and Mental Hygiene 20 10 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ${\color{red}{ ext{AUGUST}}}$ 2010 RUTH 4:00 P M BLATT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY 515 APPLEGROVE ROAD SILVER SPRING 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Min 1 🗆 M 2 🖵 F 05/18/1916 94 **Director** 102-24-2582 NYUsual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? Funeral 515 APPLEGROVE ROAD 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALESPERSON RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental ⊢ မ ISIDOR **EDELSHEIN** SARAH KRONENTHAL and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health ar, ISADORA P. WEINER/DAUGHTER BRATTLEBORO ROAD, JACKSON, NJ Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date t o **= .º** 1 Burial 2 Cremation 3 K Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) BETH MOSES CEMETERY 08/10/2010 PINELAWN, NY Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Peath ALZHEIMERIS DISEASE Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month Month 4 ☐ Pregnant at time of death 9 ☐ Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 1 No Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4

Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide after death Director; / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title D09834 3720 FARRAGUT AVE KENSINGTON, MD. 20595 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARRY ROSEMBAUM 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 20°10 Raymond Edwin Birger 10:40 A M Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 81 Eastford Court Baltimore Baltimore 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, July 18 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 □ F Min. Hours Mary and 214-72-7523 53 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "natural", or item-on any injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 3 4 1 Md. 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 81 Eastford Court 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14 Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Building Management Stationary Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edwin E. Birger Grace L. Carney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary G. Alessi/ Sister 148 Greenmeadow Drive Timonium, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 18-10-10 Towson, Md. by Funeral ervice Lic 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line, 23a. Part 1. Enter the disea shock, or heart failure Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of **Examiner** quentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 2 No the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Director: After this certificate has been din by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital Other: 2 X No ျှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 ALBERT CARLOS 11:47 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE CITY BALTIMORE 9. Birthplace (State or Foreign Country) N.C. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 6. Sex **Funeral** 8. Date of Birth 1 🗷 M 2 🗆 Days (Month, Day, 217 38 8075 69 1/21/1941 NC Director Usual Residence of Decedent 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified XX Yes 2 No Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1039 Reverdy Road 21212 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Partner In Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Addiction Counselor Recovery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert Carlos Martha Carlos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212Margaret Carlos-Wife 1039 Reverdy Road Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Trinity Cem. 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 08-14-10 Baltimore, MD 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Lio 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one duse on each line. Immediate Cause (Final Onset and Death Sepsus Physician/ Severe disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 24 hr Coayulopathe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine been signed by the attending physician and should be detached for use as the burial-transit Cirrhens Due to (or as a consequence of) Physician/Medical Encephalopathe Hepatic Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours afferd death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Tyes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☑ No 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d, Date signed (Month, Dav. Year) RES 000 8/8

DHMH 17 Rev 7/2009

Registrar

RAVEN

BLVD, BALTIMORE

MD

21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

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NWE

ZIN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28 Maryland / Department of Health and Mental Hygiene 0 1 0 trar

Certificate of Death

Reg. No. For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0141 Ам 08-07-2010 Irene Theresa Chilton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 06 - 03 - 19 27 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Country) MD Months 1 □ M 2 🔯 F 83 Director 216-20-1172 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show 28a-f shov Bel Air 1 ☐ Yes 2 No Harford Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21015 1614 Prindle Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1∐Yes 2<mark>X</mark>No ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Services permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other tha any Injury or other traumatic event, Ital. Once. Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Green Stanley Kolodziej 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 F. Broadway Bel Air, MD 21014 19a. Informant's Name/Relationship (Type. Print) Denise Sappington (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 08-10-2010 Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Rome of BelAir 21. Signat re of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a constituence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine and -tran CERT PROTECTION APPROVED BY MEDICAL resulting in death) Last Due o (or as a consequence of): attending physician a for use as the burialthat the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 2 Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No ဥ 28a. Date of Injury 28b. Time of Injury Injury 28c. Injury at Work? 27. Manner of De th 28d. Describe how injury occurred Certification: or Attending 5 Pending Subject fell 1 ☐ Yes 2 No 2 Accident June 17,2010 7:15 p.^M investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1614 Prindle Dr. 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Driveway Bel Air,MD within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the distribution of the death occurred at the time, date and place, and due to the cause(s) and due to the cause(s). 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of ce tifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Mikityanskaya

State Registrar

Baltimore,

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Records,

Vital

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Division

500 Upper Chesapeake Drive

Bel A11, MO 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:55 AM Shirley Rae Cox august ष्ठ 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death LORIEN Bel A-11 TIARTORP Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-14-1930 Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min 1 □ M 2 👿 F 79 212-26-1197 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 USA 2226 N. Tollgate Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Schools Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugenia A. McMahon William H. Ulrich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Wyandt (Daughter) 2226 N. Tollgate Circle Bel Air, MD 21015 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 08-10-2010 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

To the Hospital or Attending Physician; The law requires that the death certificate be executed

is been signed by the should be detached

certificate has

After this of funeral dire

neral Director: A

within 24 hours a

Division of Vital Records, P.O. Box 68760,

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. mt: If item 27 is marked other than

event, the Medical

or other traumatic

Director

Completed by Funeral

Be

within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

X O

Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans attending physician for use as the burial

Physician/Medical

2

Completed

Be

Certification: To

Medical

ope	cause on each line.			
a	PARKINSON'S Due to (or as a consequence of):	DISEASE	ENDSTAGE	
b	Due to for as a consequence offi-			
c	Due to (or as a consequence of):			
_d				

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death

3 🗌 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKES YPERTENSION. GERD

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 Probably 4 Unknown

24a. Was an autopsy perform 1 ☐ Yes 26. Place of Death (Check only one, 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25.		referred to medical
	examiner?	
	1 □ Yes	2 No

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 Suicide

28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28h Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29b. Signature and title of certifier

determined

29d. Date signed (Month, Day, Year)

ompleted cause of death (Item 23a) (Type, Print)

40 HAVRE DE GRACE MD 21070 SH 6225. UNION AVE, 32 Registrar's Signature 31. Date filed (Month, Day,

State Registrar

AUG 10201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 20ÎÖ A^{M} Mary Nancy Cullison 5:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Linthicum Heights Anne Arundel Tate Hospice House Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🏋 F Davs Hours Dec 4. 1947 Maryland Director 216-48-9785 62 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Anne Arundel Linthicum Heights Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 USA 203 Cheddington Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Madilyn Biddel Edgar Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Cheddington Road Linthicum Heights, MD 21090 John G. Cullison III, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/09/10 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Pamation Society Of Maryland, Inc. 9 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one seuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Host ital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Fun, ral Director. After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown within 24 hr urs after det th.

To the Funcral Director After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 1 ☐ Yes 2 ≠ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 ☐ Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No. Other: 1 🔲 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 📉 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Continuing Nurse Practice on To the basis of examination and/or investigation, in my opinion, death and place, and due to the cause (s) and manner as attack. 29b. Signature and title of certifier 15 20. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Date filed (Month, Day, Year)

ncq,

16

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0143 PM Carter 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore Secours HUSpita 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Hours Min 07 19 218-64-0967 Director MD 55 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Baltimore NA MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21216 4125 Woodhaven 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Convention Center Cook <u>10th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen V. Towns Milton Carter Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodhaven Ave, Baltimore, Md 21215 4125 Denise Hynes Carter-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State King Memorial Park 8/13/2010 Woodlawn, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Av Signature of Funeral Service Licenses or Baltimore, Md 21215 Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hente disease or condition Medical resulting in death) Examiner per ten Sequentially list conditions if any local is cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Attending 2010 Physicia Bon Secours Hosp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Inompson 31. Date filed (Month, Day, Year) State AUG 10201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Joseph Cornfeld 12:15 August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8925 Cherbourg Drive Montgomery Potomac Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. **Funeral** Country) 1 🙀 M 2 🗌 F 84 Months Days Hours Min (Month, Day, Year Director Dec. 179-36-3919 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Potomac 1X Yes 2 ☐ No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20854 8925 Cherbourg Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No 1952-Yes, Give 1954 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Medical Radiologist permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other thany injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Naomi Baum Samuel Cornfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8925 Cherbourg Drive, Potomac, Maryland 20854 Edward Cornfeld/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/8/2010 Falls Church, Virginia 4 Donation 5 Other (Specify) National Crematory 21. Signature of Funeral Service Licenses 22. Name an Dath sant Blow Goldberg Memorial Chapels, Inc. C6 Leenhar 1170 Rockville PIke, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ALZHELMERS **YEARS** ADVANCED disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours. fler death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the humal. Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, it my opinion, weath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Vikramaditya. D. Reddy AUGUST-07-2010 D43464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE, MD_20852 11125 ROUKVILLE PIKE, SUITE 208

DHMH 17 Rev 7/2009

State Registrar VIKRAMADITYA.D. REDDY

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cornish 08 06 2010 5:15a. Medical Marie 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Envoy Nursing Pikesville Home If Under Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Months Days Hours (Month, Day, Year) 93 Director 16 7-12-9455 MD Usual Residence of Decedent or 28a-f show notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Pikesville 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 U.S.A #236 Sudbrook Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces Black, White, etc. ò 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant 2th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Maggie Sanders James Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise C. Wali-Granddaughter <u>7119 Walnut Ave, Baltimore, </u> Md 21208 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 8/10/10 Woodlawn, Md Woodlawn 1. Sign tu gof Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21215 Ave. Baltimore, part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiac disease or condition resulting in death) arrythemin Medical Due to (or as a consequence of): Examiner heari duesse theresclaratie Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) by pentension or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Yes the detached 9 Unknown Division of Vital Records, P.O. After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation a er death Director A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

€ V State

DHMH 17 Rev 7/2009

Registrar

* DESTAINS

32. Registar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

030494

716 maidenthoice lane 302 Calensrille MORIRES

8-9-1010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legil State of Maryland / Department of Health and Mental Hygiene	ble.		0	0.1	0 1	
State of Maryland / Department of Health and Mental Hygiene	20	1	U	24	91	-

		1- For State Certificate of Death		Reg.	No.				
Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yes							
Medical Exam	iner	Bradley Scott Daum		August 6, 20	10	2218 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo Upper Chesapeake Medical Center Bel Air	ocation of Death		4c. County of Death	1			
			1011-d 0411 1	O. Data of Birth (Harford				
Funeral Director		Months Days	If Under 24Hrs. Hours Min.	•	MM/DD/YYYY) 9. Bir Foreiç	n			
Directo.		134-62-6490 1x M 2 F 35 Yrs.		May 30	, 1975 co	untry) New York			
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	·	-		10d. Inside City Limits			
* ,		Maryland Harford Edgewood				1 Yes 2 No			
Maryland r 28a-f sho ed at once	cto	10e. Street and Number 10f. Zip Code		10a.	Citizen of What Cour				
or 28	Director	2 Pailman 7 7		1.3		,			
with t		3 Railroad Avenue 21040 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa	anic Origin? (Spec	ifv Yes or No-	USA 14. Race - Ameri	can Indian, Black,			
eath vitem	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, N			White, etc.	,			
fire d		3 Widowed 4 Divorced If Yes 2 X No s	specify:		Specify: Wh	ite			
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation			b. Kind of Business/I				
6 172 h an "n cal E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. Do	O NOT use retired	1)					
5-0036 led within 7: Tygiene. other than	Ē	2 Mortgage Br	roker		Financia	L			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medics			.Mother's Name (F	irst, Middle, Maid	den Surname)				
7. p e e s	o Be	Frank Henry Daum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street an	Kathleer	n (nmn)	Breinling	er Z- 0-day			
MD 2 d 2 shoulth and M n 27 is n	ြ								
		Leslie N. Daum / Wife 3 Railroad Av 20a. Method of Disposition 20b. Place of Disposition (Name of cemet	tery, EC		Dc. Location - City or				
2 8 9 5 5		1 X Burial 2 Cremation 3 Removal from State crematory or other place)							
다 팔 등 다 그		4 Donation 5 Other Specify: Nolly Hill Mem. Gdr. 21. Signature of Funeral Service Livens of Signature of Funeral Service Livens of Signature of Sign	ns. 8-11 Facility	10	Baltimore	, Maryland			
Balt permit Depart Import	8.9	21. Signature of Funeral Service Litenson 22. Name and Address of MCCOMAS Full 1317 Cokes	ineral Ho sbury Rd	me, P.A	don MD 2	Inna			
Physician		I 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc	ich as cardiac or re	espiratory arrest,	shock, or heart	Approximate Interval			
/Madinal	2.5	failure. List only one cause on each line. Morbid Obesity associated Cardiovascular Disease	d with At	heroscl	erotic	Between Onset and Death			
Examiner		or condition resulting in death) Due to (or as a consequence of):							
	ایا	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				ļ			
	<u>ا</u> ۋا	cause. Enter Underlying Cause							
E. B. E.	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			- 3				
executed and and trans	I	d	-006 0 27	10					
- 9 · 5 · 6	Medica	x UNPENDED AMENDED 23a, pt.II,27 per me g	3900 8-27						
		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy	I .	23d. Date of delivery Month D	ay Year			
Box 68 e death certifi the attending ed for use as in	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	jarrapia pi agriaria)						
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown							
that the detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.		co use contribute to t				
S, P.C.	ed	Cocaine Use				ably 4 Unknown			
ord w req as bee	E E			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of			
Rec The la	Completed			performed 1 Yes 2		s 2 No			
ital Records ician: The law requi s certificate has been rector, page 2 should	Be		Death (Check only		•				
Physic Physic rethis	P	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA			idence 6 Other:				
ion of Vital tending Physician: anth. or: After this certifi the funeral director,	ᇹ	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury a		d. Describe how	injury occurred				
isior Attendary death rector: by the	[ati	2 Accident Investigation	2 No						
Division of Vital Records, P.O pital or Attending Physician: The law requires that tours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detae	ertification:	3 Suicide 6 Could not be determined (Specify)	aing, etc. 28	or Town, State)		al Route Number, City			
Hospital 24 hours Funeral	아	29a. Certifier	and place, and due	a to the series(s)	and manner as state	d.			
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	(Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a construction one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de							
To To Go	Me	and manner stated. 29b Signature and title of certifier 29c. License nu	umber	29	d. Date signed (Mon	th, Day, Year)			
		O.C.M.E	E.	A	ugust 7, 2010				
h	- 1	30. Name and address of person who completed cause of death (Item 23a)							
Ψ		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201						
	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Regist	rar	AUG 10 2010 Sener A. Janes				<u> </u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Flemming 08ั F. 80 2010 9:50a.M Louise Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Season's Hospice 7. Age (In yrs, last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpia. Country) VA **Funeral** (Month, Day, Year)
2 12 1 □ M 2 😿 F Months Days Hours Min. Director 90 218-10-3409 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Owings Mills 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21117 U.S.A. 109 Willon Bend Drive Apt 2D 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th grade Restaurant Owner 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Carrie Ann Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
104 Pleasant Ridge Drive Apt 2230 wings Mills Ronald Fuller-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) Woodlawn 8/12/2010 Woodlawn, Md ature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 1 Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. mediate Cause (Final Onset and Death Physician/ Pulmonary Ononic Obsmohive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-transit that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 SB IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 G signed by the a 2 **N**O P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires to 24 hours after death.

 Funeral Director: After this certificate has been sinn. Records, 1 Yes 2 No 3 Probably 4 Nunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No Yes Division of Vital funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Ty when 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at naspice Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the only one) 29d. Date signed (Month, Day, Year) 818/10 Kannen Mule mo D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller Sinte 203 2835 Smith Ave Ballmor 2. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** AUDUST 2010 Fortune Harriett RED /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PALTIMORE MID If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | MD 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 216-54-1562 **Director** MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show tal Hygiene. d other than "natural", or items 23a or 28a-f shov event, the decient Event her in ust be notified at 1√Yes 2□No Director MD NA Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 106 North Monastery Ave

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? Funeral U.S.A. 21229 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2**X** No 1 ☐ Yes 🏖 ☐ No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Misty Harbour Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wii Department of Health and Mental Hyglen. Important: If item 27 is marked other tha any injury or other traumatic event, than Coat Factory 12th grade <u>Seamstress</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Mildred Johnson William Fortune 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 North Monastery Ave, Baltimore, Md
ce of Disposition (Name of Date 20c. Location - City or Town, State Lenora Fortune-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 8/11/2010 Arbutus, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenser lare 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** KIBHI SIDE MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PULMONAR sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed MRSA attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Vear Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a I be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 194 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760 Vital Records, P.O.

Maryland 21215-0036

Baltimore,

State Registrar

completely

within 2

Medical

29a. Certifier

(Check only one)

29b. Signature and fittle of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATON 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 20°I°O FAYN 6:45 P M IRINA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME PIKESVILLE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) POLAND Days 1 □ M 2 V F Months Hours 0577371925 220-29-4863 85 Yrs Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 1 X Yes 2 No N/A BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral #811 21215 USA 3601 FORDS LANE. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: WHITE Specify 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) MOVIE CHEMICAL ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fil f Health and Mental item 27 is marked ဂ္ BERLIN RAISA IOFFE DAVID 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 FORDS LANE, #811, BALTIMORE, MD LEV FAYN/HUSBAND permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 3 or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HAR SINAI CEMETERY 08/09/2010 OWINGS MILLS, MD Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VI DRECIES disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last ed by the attending physician a detached for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No g Unknown g Unknown s been signed by a should be detack art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown icate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: 2 No မှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred iniury 5 Pendina ☐ Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie of person who completed cause of death (Item 23a) (Type 000 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

ORIGINAL

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 28b per me,g906,08/10/2010dhb Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 2010 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 2:30 AM **GARFIELD** RAYMOND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Baltimore Balti more Hospital N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 07/26/1922 **1**X□ M 2 □ F Hours 217-16-1334 MD Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21209 USA 2815 LIGHTFOOT DRIVE 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Tes XX No Specify Specify: WHITE 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) GROCERY STORE OWNER **GROCERY** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ SOPHIE KLUGMAN GARFIELD ISAAC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRIS HUBERT/DAUGHTER 9212 HARVEST RUSH ROAD, OWINGS MILLS, MD Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. PARIOTUNETON/VOHTZUK Date 1

M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) AMUNO CEMETERY 7/27/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that palsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between SUBDURAL Onset and Death Immediate Cause (Final HEMATOMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Exam certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 1 Yes 2 No cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEART FAILURE CONGESTIVE 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28d. Describe how injury occurred of ound of own at home by family 28a. Date of injury (Month, Day, Year) 07-27-10 Unknown м 27. Manner of Death 28c. Injury at work? Certificate: 1 | Natural 5 Pending 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28/5 lightfoot dive, Ballinere Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one Signature and rifle of Certifie 29d. Date signed (Month, Day, Year) 29c. License number RES-000 M.S. JULY 25,2010

State Registrar

Raymous

3

SINAL

MOSPITAL OF BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABOMALTYTE

JURGA

31. Date filed (Month, Day, Year) AUG 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24924 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 0235 PM 2010 Barbara Lee Gaines AUGUST 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPIT AGNES BALTIMONSE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/27/1936 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🔀 F Months Days Hours 216-34-9544 74 N. Carolina Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No MD Baltimore Co. Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rolling Road 1525 N. 21228 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo Specify: Specify: 3 ₩ Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Records years Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McLaughlin Pearl Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 170 Chestnut Street, Turner Station, MD21222 Valerie Gaines(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 08/14/10 Baltimore, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility JOSEPA H. Brown Jr. Funeral Home PA illiamo 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Pregnant at time of death 9 Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an Was autopsy performed? 1 □ Ýes 25. Was case referred to medical

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Exemples.

/Medical

Directo

Funeral

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Completed

Be

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Lee

The law requires that the death certificate be executed attending physician and for use as the burial-transi SALBARA Records, P.O. Box 68760, signed by the atte has this certificate Vital I or Attending Physician; after death. Division

GAINE

Examine Physician/Medical ģ Completed Be Certification: To

1 [the past 12 month □Yes 2 ☑ No □Unknown	is?
Part II.	Other significant	conditions

26. Place of Death (Check only one)

1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2] ER/Outpatient	3 ☐ DOA Other:	4 Nursing Home	5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe how inju	iry occurred
2 □ Accident investigatio	n I	i	M 1 □Yes	s 2 □ No I		

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred ∃No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

3 🗌 Suicide

29a. Certifier

4 🗌 Homicide

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONDUILLO

900

BACTIMORE MD

State Registrar

Medical

31. Date filed (Month, Day, Year)

JONATHAN

32. Registrar's Signature

6 Could not be

To the Hospital within 24 hours a To the Funeral D

amend, item 20b per the 906 8-16-10 at Mental Hygiene 2 0 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kevin Giddiens 20117 Medical uga 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore Social Security Number Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Min. Hours 02770471958 Maryland **Director** 217-66-8347 52 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/ABaltimore 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6000 Bellona Ave. 21212 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates. 1

✓ Never Married 2 ☐ Married 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maryland 21 unk 12th Grade Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Giddiens Charles Hatchett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Kayden Lane, Essex, MD 21221 Holmes(sister) Karen G. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
And Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State 8-12-10 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ nfumonia disease or condition resulting in death) Medical Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner o (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant 9 Unknown 5 Other (specify) Month Year Pregnant at time of death Dav s been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မှ 1 Inpatient 2 XFR/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending after death Director: Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title o 29d. Date signed (Month, Day, Year) 2010 erson who completed cause of death (Item 23a) (Type, Print) 5601 lock Kaven BNO Day, Year, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-05	904
Rose	Gullev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 24926

		1- For State Registrar		Ce	rtificate (of Dea	ath			F	Reg. No			
Physicia Medical Exami	an/	Decedent's Name (First, Mic Rose Gulley								2. Date of Dea Month August 6,	ath Day , 2010	Year		3. Time of Death 1643 hrs
ľ		4a. Facility Name (if not instituted as 1161 Appleton Road	i			Elk	ton					4c. County of Death Cecil		
Funeral Director		5. Social Security Number 364–20–7723	6. Sex	7. Age (In yrs. 84			nder 1 Yo	ear If Unders	er 24Hrs. s Min.	8. Date of Bi 08/16/	irth(MM /192	/DD/YYYY) !5	Foreig	hplace (State or n MI untry)
Maryland 28a-f show any d at once.	tor	Usual Residence of Decedent 10a. State 10b. Count MD Ceci			, Town or Loc									10d. Inside City Limits 1 Yes 2 No
the Mary 3a or 28a- otified at	Director	10e. Street and Number 1161 Appleton					Zip Code 1921				10g. Cit US	tizen of Wha	at Cour	ntry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	by Funeral	3 Widowed 4 D	Married Armed Formal Armed Form	2 X No	If	Yes, spe	ecify Cub	an, Mexican lo specify:	, Puerto			White,	^{etc.} Whi	
036 ithin 72 hour me. r than "natu fedical Exan	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12			16a. Decedor during Finar	most of w	vorking li	fe. DO NOT	kind of w use retir	ork done ed)		Kind of Bus vivers		Of Del.
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medical	B	17. Father's Name (First, Middl Henry Laben						Katl	heri	(First, Middle, ne Meir	har	ď		
- p = s	٩		nship (Type, Print)	Lag	6456	Abe	l St	.,Elk		ural Route Nur e, MD 2	2107	'5		
Baltimore, N permit. Pages I and Department of Health Important: If item		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other	Specify:	om State	Place of Dispo crematory or o lantic	other place Cren	∞) nato:	rу		Date /2010	Gl	en Bu	rni	e, MD
		21. Signature of the ray Service			P	otto	ck R	ss of Facility andel	l F.	Port	Hu	eer A ron,M	I 4	8060
Physician /M i Examiner		23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	se on each line. se a. <mark>Head Injuri</mark> e			the mode	e of dyin	g, such as c	ardiac or	respiratory arr	rest, sho	ock, or hear	t	Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	е	consequence of	f):									
uted nd ransit	Examiner	(Disease or injury that initiated events resulting in death) Last	C	consequence of	f):									
760, icate be executed physician and the burial - transit	/Medical	UNPENDED	AMENDED											
Box 68760, ne death certificate by the attending physic need for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 V No 9 Ur	the 1 Live b	ant at time of de	2 F	etal deat		Ectopic	pregnan	су	230	d. Date of d Month	elivery Da	ay Year
i, P.O. B ires that the d signed by the	۵	Part II. Other significant condi			esulting in the	underlyir	ng cause	given in Pa	ırt I.		_		_	ne cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fumeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil.	Completed							·		24a. Was autop perfor 1 ✓ Yes	sy rmed?	pri de:		opsy findings available impletion of cause of
Vital I ysician: his certifi director,	æ	25. Was case referred to medical examiner?	[Hospital:	npatient 2	ER/Outpatier	+ 3	26.Plac	e of Death (Pasido	nce 6	Othor	Cana
ion of V tending Phy: eath. tor: After thi the funeral d			28a. Date of Country anding	of Injury Day,Year)	28b. Time of FOUND:		28c. Inj	ury at Work	? [2	28d. Describe i Subject fell	how inju	ury occurred	1	Scene
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To the Hos within 24 h To the Fun completely	ल	(Physician: To the best aminer:On the basis o and manner st	of examination ar										
	Ž	296. Signature and title of certifications of the certification of the c	ier Yhull		-	29		se number				Date signed ust 7, 20		h, Day, Year)
(eV		30. Name and address of person Margarita Korell MD.	Assistant Med	lical Examin	er 111 F		treet, E	Baltimore,	, MD 2	1201				
Sta Registi		31. Date filed (Month, Day Year)	32. Re	gistrar's Signatu	re park									

 ϕ

31. Date filed (Month, Day, Year)

Melissa Brassell, MD

OCME

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	of Marylar	nd / Depa <i>Cei</i>	artment o <i>tificat</i> e o	of Hea of Dea	alth and ath	Mental Hy	giene Reg. No	2010	24928
	Physicia Medic		1. Decedent's Name (First, Midd	Darren	С.	Goir	ns			2. Date of Do Month AUGUS	Da	y Year • 2010	3. Time of Death 9:52 PM
and a	Examir		4a. Facility Name (if not institutio	n, give street and nur			1	wn, or Loc	cation of Deat				
	'		St. Joseph Medical Center					owso				Baltimor	
	Funeral Director		5. Social Security Number 589–54–2054 Usual Residence of Decedent	6. Sex 1 X M 2 - F	7. Age (In yrs. 38	last birthday) Yrs.	If Under 1 N		Under 24 Hrs lours Min.		rth a <i>y, Year)</i> 19	9. Birth Coun 72 F1	place (State or Foreign htry) Lorida
	nd how	5	10a. State 10b. Count	у	10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
	faryla 3a-f s tiffied	Funeral Director	Maryland Bal	timore	C	ockeys	7i116						1 ☐ Yes 2X No
	or 2	<u> </u>	10e. Street and Number	LEIMOLC		OCKCYS	10f. Zip Co	ode			10g. Cit	tizen of What Cou	intry?
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	death item ner n	큔	11. Marital Status	Armed Fo		.S. 13. \	Nas Decedent f Yes, specify	t of Hispar Cuban, M	nic Origin? (S lexican, Puerl	pecify Yes or No to Rican, etc.)	. [14. Race - Ameri Black, White,	
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γa	uld be I Men narke natic	-	Darr		D	Goins,				Margare		Willia	
Maryland	2 sho th and ?7 is r traun		19a. Informant's Name/Relations				_						Code) 06107
	and Healt tem 2		Molly Goins Co	x Sis		Place of Dispo	Ridgewo		oad !	West Hai		d, Conne	
ΘĒ	age 1 ent of nt: If i		1 Burial 2 Cremation 4 Donation 5 Other	n 3 ☐ Removal from	State	cemetery, crer	natory or othe	r place)	_ 0 0		İ	-	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	F	21. Service		111	11top S	. Name and A						Maryland Home, Inc.
Ä	permit Depar Impor any in	l li	- Jan Victor	tagan_			1050 Yo					land 212	
			23a. Part 1. Enter the disease, c shock, or heart failure. List Immediate Cause (Final	or complications that only one cause on ea	caused the dea ach line.	th. Do not ente	er the mode of	f dying, su	uch as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	h sician/ Medical	8 7	disease or condition resulting in death)		RTTC D		LION						511001 4114 5 0441
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<i>J</i> ~ <i>u</i>	exectian ar	Ě	resulting in death) Last	Due to	(or as a conseq	quence of):							
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Box 687	ath ce attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	Birth 2 Fet	tal death 3	Ectopic preg				1	23d. Date of delive Month	very Day Year
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P.O.	es that th signed by be detad	y P	Part II. Other significant condit	ions contributing to c	feath but not res	sulting in the u	nderlying caus	se given ir	n Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
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a	sician: The certificate rector, pag	Be	25. Was case referred to medica examiner?				2	26. Place o	of Death (Che		2 7000	7	7
Ξ	Physic this ce al direc	卢	1 ☐ Yes 2 XNo	Hospital:	Inpatient 2 🗆		t 3 🗆 DOA	Other: 4	I ☐ Nursing I	fome 5 🗆 Resi	dence 6	Other (Specification)	y)
Jo (ing Ph	ate:	27. Manner of Death 1 Natural 5 Pend 2 Accident Invest	ing 28a. Date	of injury hth, Day, Year)	28b. Time of injury	1	Injury at work?	_	28d. Describe	how injury	occurred /	
jo	ttend death stor: A	Įį.		tigation d not be	af laire. At h	ama farm atu			2 🗆 No	00/ 1 11			
i	Cause (usease or injury trainitated events resulting in death) Last Due to (or as a consequence of):									i Route Number,			
	spita hours neral filled		29a. Certifier 1 X Certifyin	g Physician: To the b	pest of my know	vledge, death o	occured at the	time, date	e and place, a	and due to the ca	ause(s) an	d manner as state	ed.
	he Ho in 24 l ne Ful pletec	Medical	(Check 2 Medical	Examiner: On the bas g Nurse Practioner:	sis of examination	on and/or invest	igation, in my	opinion, de	eath occurred	at the time, date	and place,	and due to the ca	ause(s) and manner stated
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	10		30. Name and address of person										
	1		RICHARD LI 31. Date filed (Month, Day, Year)	·	M D .	7601	OSLE	R DE	RIVE	rowson,	MAR	YLAND 2	21204
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 2010 SYLVAN GOLDSTICK 1:05 A M Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE FUTURECARE CHERRYWOOD REISTERSTOWN Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days 0397171932 213-32-2334 78 Director Usual Residence of Decedent 28a-f shov 10h County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE RANDALLSTOWN MD 10e. Street and Number 10g. Citizen of What Country? Funeral 9111 MEADOW HEIGHTS ROAD 21133 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CITY PLANNER STATE OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HENRY GOLDSTICK MILDRED **PRESSMAN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA GOLDSTICK/WIFE 9111 MEADOW HEIGHTS ROAD, RANDALLSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/09/2010 BETH TFILOH CONG. BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Mar 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Merastatic u are hi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 00 Hospital: Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number P47683 Engrand Miller MD

State

Raymora 31. Date filed (Month, Day, Year) 32. Registrar's Signature ORIGINAL

Snigh

fre

Balhowe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

millio

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh g906 8-10-10 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 12:25 OM **Physician** /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Hours Min. NA 8. Date of Birth (Month, Day, Year) 12-25-37 Birthplace (State or Foreign Country) If Unde 7. Age (In yrs. last birthday, **Funeral** Months Days 102 M 2□ F MN Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or other traumatic event, the Medical Exactiner must be positive at Director ty⊡ky*es 2 □ No MD NA Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ö USA 21206 6116 Belair Road "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes X No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: þ Specify: White 3 ☐ Widowed X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flementary/Secondary (0-12) 12th Grade and Mental Hygiene. is marked other than College (1-4or 5+) Laborer Motel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson Harris, Sr. Florence John 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Calvert Street Suite #300 Baltimore 10 N. Cassandra Lucas 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X remation 3 ☐ Removal from State Metro Crematory 08-12-10 Catonsville, MD 4 □ Donation 5 □ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service License 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Paul. Er er the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one ask on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (o as) consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner uence of the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): physician a Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mon 1 ☐ Yes 2 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknow ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, à 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate has 2 No 1 □Yes No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Certification: To this 27. Mann of Death in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 □ No death. 24 hours after death e Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601-Loch

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 24931 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hollev Fannie M 7:15 A 2010 08 Medical 4a, Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Convalescent Center Crofton Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. June 26, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Year) 1915 Alabama Hours Min. 1 🗆 M 2 🕱 F Director 95 Yrs. 214-16-8673 Jsual Residence of Decedent 10a. State 10c. City, Town or Location . Page 1 and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene. 10d. Inside City Limits Director be notified 28a-f Anne Arundel Crofton 1 ☐ Yes 2 🛣 No MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral U.S.A. 2131 Davidsonville Road 21114 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? 6 Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes Give **Black** "natural", Specify: 3 Widowed 4 N Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic ever မ Aurther R. Holley Pinkie Oree 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i MD 21225 Mrs. Claudette G. Royal 3258 Gulfport Drive Brooklyn, item 2 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 Cross Cemetery Baltimore, MD 21. Signature of Funeral Source Licensee 22. Name and Address of Facility Singleton Funeral and Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01220 23a. Part 1. Enter the disea of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to ar as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed ?4 hours after death. use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director, A: M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane M Bowie, MD 20715 Rakesh Arora, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 24932 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 8 Day 2010 Year 11:25 A_M HAZEL WOOD HILL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE Baltimore County Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Months 1 □ M 2 🔯 F Hours $J_{\rm ully}^{(Menth, Days)}$ $29^{(Year)}$ 1925Director 85 Maryland 215-54-1544 Jsual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 705 Fairway Drive 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 💢 No Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Residence Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley Earl Wood, Sr. Minna Louise Hood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Hill Roberts (Daughter) 2 Lochmoor Court, Lutherville, Maryland 21093 Important: If item 27 any injury or other tr once, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 8/11/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service trochsee

Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) LIVER CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 24 hours after deat Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, data and place, and due to the names(s) and manner as stated

Registrar DHMH 17 Rev 7/2009

State

B

29b. Signature and title of ce tifier

JACKIE JONES,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a.m.

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CRNP 2300 DULANEY VALLEY RD.

32. Registrar's Simature

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 24933 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ AWONTH G 1000 AIRE Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner REI. 1CKERSGILL COMM. MD BALTIMORE BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Funeral 2/20/26 Year) 1 M 2XXF New York 102-22-9687 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Tes 2 XXVo Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21204 615 Chestnut Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: White 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) ည Irene O'Connell Cornelius Gerard Cullinan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Chestnut Avenue Towson, Mary Land 21204 Richard Allen Hartman Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
St Mary's Cemetery 1XX Burial 2 Cremation 3 Removal from State Aug 9, 2010 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the diseas for complica shock, or heart failure. List only one Ans Hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1+ Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Certificate: To Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Division of Vital Records, P.O. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? abstructive leny disease 1 Yes 2 No 3 Probably 4 Unknown porosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ieral Director: After I filled in by the fune 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signat rson who completed cause of death Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

32. Registra s Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20b Copies FH, G906, 8/10/2010 WS State of Maryland Department of Health and Mental Hygiene 20 10 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Hammond Jr. Calvin R. 05 2010 5:11p. 08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Stella Maris Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 1 **X** M 2 □ F Hours Director 45 217-80-1838 09 01 64 or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Essex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 21221 U.S.A. 115 Country Terrace Road Apt 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Should Le mon...h and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should te filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Walmart Greeter 9th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lucille Moses Calvin Hammond Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Country Terrace Road, Essex, Mđ Bonita Hammond-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date King Memorial
Arbutus Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/12/10 Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 👿 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 X Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Cartifying Nurse Practioner: To the best of my knowledge d at the time loats and place

D.B.

AUGUST

CALVIN HAMMOND

State Registrar 29b. Signature and title of cert

JACKIE JONES,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

2300 DULANEY VALLEY RD.

32. Registrar's Sinature

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24935 State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUG. 7, CATHERINE L. HENN 6:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE HEALTH & REHAB. GLEN BURNIE ANNE ARUNDEL CENTER Social Security Number 6. Sex 7. Age (In vrs. last birthday, If Under If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** ^{Year)}1925 1 🗆 M 2 🗓 F Days Hours NOV . I'9 84 MARYLAND 217-20-2004 **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar must he material and injury or other traumatic event, the Medical Examinar must he material and injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗆 Yes 2 🗓 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 7885 GORDON CT. UNITED STATES 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 🗌 Yes 2 ី No Specify: 3 X Widowed 4 ☐ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CONVENIENCE STORE CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ FREDERICK PRIEBE LOUISE K. LOTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 PINE DRIVE, PASADENA, MARYLAND 21122 TIMOTHY P. HENN / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date AUGUŠT 2010 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) BALTIMORE NAT. CEM. Donation 5 Qther (Specify) BALTIMORE, MARYLAND ure of Romeral Se me and Address of Facility
KLEY-RUDDICK
CRAIN HWY., 21. Sign FUNERAL HOME, P.A. S.E., GLEN BURNIE; MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown q Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\frac{1}{2}\) No 2 🗌 No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🛛 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accider 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 🗆 Certifying Notes Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

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29b. Signature and title of certific

AUG 102010

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29d. Date signed (Month, Day, Year) AUGUST 9, 2010

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

M.D. 110 West Road Bldg A. #201 Towson MD, 21204

Secada-Lovio,

Jorge C.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g906 8-10-10 yt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2010 24937 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Janice 2010 J. Horsey AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES 13AL HOSPITAL LTIMOKE 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Octobb, Day, Year) **Funeral** 1 □ M 2 □ E Months Days Hours Min. 215-54-4162 56 Director Aug. 15, 1953 MD Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examinar must be notified at MD n/a Baltimore Director 1 XYes 2 □ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 820 S. Caton Ave. Apt 7B 21229 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Deceden Lv Armed Forces? 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2√ No Specify: Completed by Specify Black 3 ₩idowed 4 Divorced "natural" Health and Mental Hygiene. tem 27 Is marked other than "natur other traumatic event, It of Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Bar Maid Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Diggs Mary Richardson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charice Diggs /Grand Child 3508 Round Rd. Baltimore, Md 21225 other t Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.Carmel Cem. Aug.12,2010 Balto,Md. Signature of Funeral Service Licensee 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Preston St. Balto, Md. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) OXIC ercephal /Medical Due to (or as a consequence of): Examiner COTT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 2 🗆 No Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) manner stated. 29b. Signature and title q certifier 29c. License number D41843 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOGOOCATONAVE BALTIMORE, MOZ PEED Year) do 31. Date filed (Month) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:30p Jul 31, 2010 Year Ida Hardy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death **Baltimore** Towson Gilchrist Center for Hospice Care 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) Jan 4, 1964 1 M 2 W Months Days Min. No. Carolina Director 245-11-2742 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No 28a-f Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral U.S.A. 21206 5469 Cedonia Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Black Specify: "natural" 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Own Home Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura Hardy Preston Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 King Charles Circle Baltimore, Maryland 21237 Preston A Hardy 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 DxBurial 2 Cremation 3 Removal from State any injury or Windsor Mill, Md. 08/05/10 King Memorial Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Service Licensee Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 Enter the discusse, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, beautifulure. List only one cause on each line. Approximate Interval Between Onset and Death shock. Immediate Cause (Final √Physician/ Netastoxic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No
9 Unknown Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 20 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No this certificate 1 🗌 Yes 2 🗆 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1
Yes Certificate: → atural

Accident

Suic Natural 5 - Pending injury 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Eertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) CQ

State Registrar

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

tral

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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AUG

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 24939 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August Physician/ Year 7:45 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4721 BYRON ROAD BALTIMORE BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. Country) GERMANY 1 ☐ M 2**X X**F 0172471925 213-20-9277 85 Director Yrs. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2x No MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 4721 BYRON ROAD 21208 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. . Or Completed by 1 \square Never Married 2 \square Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3X Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hyglene. HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ PHILLIP BANEMAN JEANETTE CAHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i DEBBIE HESS/DAUGHTER 3317 WOODVALLEY DRIVE, BALTIMORE, MD 21208 20a, Method of Disposition 20b. Place of Disposition Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🎇 Burial 2 □ Cremation 3 □ Removal from State CHESED CEMETERY 08/08/2010 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Lisensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Kena e disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): nding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XNatural 5 Pending work? 1 Tes Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0057256 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pallavi Kumuv 2401 West Belvede re Avenue, Baltimore. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6:00 PM Melvin W. Inners ugust 2010 4a. Façility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Hartord At BEL -ORIEN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1√ M 2□ F Yrs. 90 213-16-3140 November14,1919 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 X No Nottingham Md. Balto. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number IISA 21236 7903 Hilltop Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1,⊡Yes 2 □ No IfYes, Give Year or Dates:1944–1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Logistics Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel M. Zimmerman Frank B. Inners 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 108 Boxthorn Road abingdon, Md. 21009 Niece Susan Marecki 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 8-12-2010 Timonium. Md. 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home 21. Signature of Fundal Service Icensee 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) STAGE-4 LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 □Yes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760 attending ph for use as the been signed by the should be detached certificate has be irector, page 2 sl this After th funeral hours after death. uneral Director: Af 24 hours within 2

Physician

Examiner

Funeral

Director

in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

marked other

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once.

Physician

/Medical

Examiner

2 should be fi and Mental F is marked ot

Directo

Funeral

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Completed

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Examine

by Physician/Medical

Completed

Be

Certification: To

Medical

State

29b. Signature and title of certifier

SURESH

31. Date filed (Month, Day,

AUG 102010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

director,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Registrar

DHMH 17 Rev 1/2001

6225,

Signature

UNION ANE

29c. License number

1)45344

HAYRE DEGRACE.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 7 2018 110 c/m William T. James Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1801 Middleborough Road Essex If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 213-84-9953 1 X M 2 🗆 F Months Hours Country) April 129, 1959 Director 51 MD Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Essex Baltimore 28a-f 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21221 1801 Middleborough Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Handy Man self-employed 12th permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sue MArtin William T. James Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Laubach /sister 1801 Middleborough Road Baltimore MD 21 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 8/9/10 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial A Cremation 3 ☐ Removal from State
4 ☐ Donarion 5 ☐ Other (Specify) Baltimore MD 22. Name and Address of Facility 300 Mace Ave, Balto. 21. Sign tup 617 er L. en ice Lice et e MD 21221 Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequente of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last law requires that the death certificate be executed ding physician and se as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Laboris M 2 ☐ No 3 ☐ Probably 4 ☐ Unknown TOBONCO ABUDE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Hospital or Attending Physician: The 24 hours after death. 1 🗌 Yes 2 🗎 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pendina 1 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 185 acu

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

0 2010

32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24942 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 127 Mary Lou <u>Jackson</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner osedale HUS pital Center Baltimore quare 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day,) 01 06 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Min. 1 □ M 2 □ F Days 217-24-0854 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at **Funeral Director** Baltimore MD NA 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? filed within 72 hours after death with 1315 Chesaco Ave Apt 315 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Waryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Insurance Coverage Technician 12th grade 2yrs+ Social Security Adm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Oscar Allen Burrell Stella G. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belvieu Ave, Baltimore, Md 21215 4502 <u>Joslyn J. Starvis-Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State On-Site 4 ☐ Donation 5 ☐ Other (Specify) 8/14/2010 Baltimore, Md Funeral Service Licensee 21. Signature 22. Name and Address of Facility March F/H West 300 Wabash Ave, Baltimore, 🖊 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between lock, or heart failure. List only one cause on each line. Onset and Death nediate Cause (Final Heart Failure stive Physician/ disease or condition resulting in death) Medical consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown n signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should l 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☑ No Yes 2 1 25. Was case referred to medical eral Director; After this certific filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗀 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4

Homicide determined City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and the

State Registrar DHMH 17 Rev 7/2009 KRIC

31. Date filed (Month, AUG

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Frankli

son who completed cause of death (Item 23a) (Type, Print) 9000

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cynthia Cedonia Johnson Month Day Year 9:35pm 08 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care Nursing Home <u>Baltimore</u> ecurity Numb 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 □**y** Months Hours Min 8 22 52 Director 215-60-3065 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 3430 Parklawn Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) lth grade Counselor Mount Manor Rehab. Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Mary Montague 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parklawn Ave, Baltimore, 21213 Damon Montague-Son Md 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park8/14/201 Woodlawn, Md anature of Funeral Service Licens 22. Name and Address of Facility March F/H West 4300 wabash Ave, Baltimore, Md . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death wock, or heart failure. List only one cause on each line Ima ediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner tuman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 No been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 1 Yes Unknown page 2 should 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of perform Director: After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deal Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 0062194 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

State

Registrar

31. Date filed (Month, Day, Year,

AUG 1 0 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 0 500 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N. Bond St Baltimore If Under 1 Year If Under 24 Hrs. Sex 1 M 2 □ F 7. Age (In vrs. last birthday 8. Date of Birth Apr. 20, 1916 Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Hours Country)
MD 220-10-5803 94 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notitied at once. 10b, County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore Yes 2 No 10e. Street and Number 10g. Citizen of What Country? USA 21231 117 N. Bond St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2X No 21215-0036 1 Yes X No Specify: Specify: 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Life Saver Corp. Candy Maker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lawrence Jefferson Alverta Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 N. Bond St. Balto, Md. 21231 Odessa S. Jefferson (wife) Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Aug.13,2010 Baltimore, Md Donation 5 Cother (Specify Entombrie WoodLawn Cem 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of): Examiner 68 Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of, the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death certificate has been signed by the rirector, page 2 should be detached 9 ☐ Unknown 9 Unknown uting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 🗌 Yes Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to dical Be 26. Place of Death (Check only one) examiner? Hospital: 2 Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending ✓ Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature any 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

30. Name and

31. Date filed Mont

completed cause of death (Item 33a) (Type, Print)

s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20lo Physician/ Richard 0236 AM ENNOTH August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkius Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. Maryland Months Days Hours 1 🌠 M 2 🗆 F 212-48-0068 63 1946 Director December. Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho of Health and Mental Hygiene. item 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 3126 Cornwall Road 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1

Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel 12 years Machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Elizabeth Rose Kizman Richard Henry Hall Johns Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9008 Avenue B, Edgemere, Maryland 21219 William R. Johns Sr. Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 10. Department of I Important: If its any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, Maryland 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of 7110 Sollers Point Road, Home Of Dundalk, P nt Road, Dundalk,Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ hypoxia disease or condition Medical resulting in death) Due (or as a consequence of): **Examiner** wou Sequentially list conditions, Examiner ue to (or as a consequence of): if any, leading to immediate as the burial-transit Cause (Disease or iinjury that initiated events lung cancer Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be 2 No Other: 1 Tyes Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural N 5 Pending ☐ Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one)

State Registrar 29b. Signature and title of certifier

Heather 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AParsons

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

7,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>010</u> Physician/ Month James August 8 1:17 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea October 26, 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 XF Months Hours Min. 216-28-1398 Maryland Director 76 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1700 Leslie Road 21222 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🂢 No If Yes, Give 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Irving McCauley Josephine Chester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jodi Kurth Daughter 1700 Leslie Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 12, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Donation 5 Honor (Specify) Bayview Crematory Baltimore, Maryland 2010 Signature of June al Service Licensee ²². Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A 7110 Sollers Point Road, Dundalk, Md 21222 implications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ memone disease or condition resulting in death) Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated quents Examine Due to (or as a consequence of): and -transit that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical þ Completed

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Be

Certificate: To

Medical

only one) 29b. Signat

31. Date filed (Month, Dav. Year)

e and title of certifie

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	23d. Date of de Month	elivery Day	Year						
Part II. Other significant conditions				ng cause given in Part I.	23e.	Did tobacco u	use contribute to	o the caus	se of death?
Chronic OGS			,	SIJEKJE,	-	1 🗆 Yes 2	□No 3□F	robably	4 Unknown
Restrictive			it, con	festive	24a.	Was an autopsy			dings available on of cause of
heart Sail	re			3	1 🗆	performed?	death?	s 2 🗆 N	
25. Was case referred to medical examiner?				26. Place of Death (Ch	eck only one))	erve-servitore		
1 🗆 Yes 2 🔀 No	Hos	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5	Residence 6	Other (Spec	cinhas	spire
27. Manner of Death Natural 5 Pending Control Investigat	tion	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No		ribe how injury	7		
3 Suicide 6 Could no 4 Homicide determine		28e. Place of Injury - At he building, etc. (Specify		tory, office		tion (Street and or Town, State)	d Number or Ru)	ıral Route	Number,
29a. Certifier Certifying P	hysicia	an: To the best of my know On the basis of examination	rledge, death occured on and/or investigation,	at the time, date and place, in my opinion, death occurre	and due to to	he cause(s) an date and place	d manner as st	ated. cause(s) a	and manner stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Date signed (Month, Dav. Year)

State Registrar

within 24 hours a To the Funeral Completed filled

who completed cause of death (Item 23a) (Type, Print) UZS

Please Type or Print in Black Indelible ink 15 nsure Alk Copies Are Legible.

Amend Item 11 per spouse Global Item 11 per FH G909 of 1/23/1 and Mental Hygiene

Amend Item 11 per FH G909 of Death

Reg. No. 2 1 1 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7:370 Cindy L. King 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 624 Delaware Avenue Essex Baltimore Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 🗆 M 2 🔀 F Months Days Hours Feb. 8, 1955 Country) Director 213-68-1870 55 MD Usual Residence of Decedent 28a-f shov 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits at the Maryland Director notified MD Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be with t 23a Funeral 624 Delaware Avenue 21221 USA items 2 hours after death 11. Marital Status x Divorced 2. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married o, ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working within 72 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Medical 12th Materials <u>Handler</u> and Mental Hygie is marked other be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Perry Wilt Betty Andrews traumatic Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Jessica King /daughter 423 Lorraine Avenue Baltimore MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Cemetery 8/10/10 N Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sorvice Licenses 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the duth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ -uns Conce disease or condition Medical resulting in death) Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of: the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IE EEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No Month Dav Year ☐ Pregnant at time of death☐ Unknown signed by the a 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **≥** Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 🗌 Yes 2 \square No Yes completed filled in by the funeral director, å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural Injury 5 Pending work s after death. 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 Ceg fying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated certifier 29b. Signature 29d. Date signed (Month, Day, Year) 9 24356 2010 ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Ste. 2200 Baltimore, MA Frank 32. Registrant Signat State AUG 1 Registrar

Day Month **Physician** KUNIN IKTOR 05 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Months 1.2M 2□ F 07/01/1926 216-45-0240 84 Director Usual Residence of Decedent 10b. County Baltimore death with the Maryland 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at Directo MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 1450 BEDFORD AVENUE, APT. 617 21208 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or iter any Injury or other traumatic event. the Medical Examina 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ If Yes, Give Year or Dates: Specify: Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FINANCE OFFICER FOOD INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MIKHAIL KUNIN ANNA SHEMANOVICH 19a. Informant's Name/Relationship (Type. Print)

Yablochnikov

MARINA YABLOCHINKOV / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6934 CLEARWIND COURT, BALTIMORE, MD Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of ZIII) conference from a for sine place K 1 Burial 2 ☐ Cremation 3 ☐ Removal from State AMUNO CEMETERY 08/06/2010 BALTIMORE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GASTRIC **Physician** CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed? 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending Phours after death.
Ineral Director: After ty filled in by the funera Certification: 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

ATTONDING PHYSICIAN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L(VIND/ILE

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

Reg. No

2010

N/A

01:45 AM

UKRAINE

10d. Inside City Limits

1 X Yes XX No

Birthplace (State or Foreign Country)

WHITE

MD

Day

Year

21215

Month

08-05-2010

2. Date of Death

amend #10b 19a Per FH G906 8/10/2010 Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

BABATUNDE 31. Date filed (Month, Day, Year)

AUG 1 0 2010

2434 W. BELVEDELE

D0064533

UGRIATRIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24949 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mildred Elizabeth Kotvis Physician/ August 4, 2010 Year 6:07 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🏝 F Months Days Hours Jan. 4, 1910 100 **Director** 391-01-2920 Wisconsin Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 🖾 Yes 2 🗌 No Wisconsin Milwaukee Franklin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10879 South 76th Street 53132 Wisconsin Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. ō 1 X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates White 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Small Businesses Bookkeeper and Mental Hygie is marked other be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item Z7 is marked any injury or other traumatic ev once. Nora Smith Isaac Peter Kotvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11117 Tara Road, Potomac, Maryland 20854 Delbert D. Smith/Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 11, Ar lington Park 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Milwaukee, Wisconsin 4 ☐ Donation 5 ☐ Other (Specify) 2010 Cemetery Robert A. Pumphrey Funeral Home/ Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses M00198 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardioc or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death m Immediate Cause (Final Ph_sician/ Subdural Hematoma Medical resulting in death) Due to (or as a consequence of): Examiner Severe Traumatic Brain Injury 4 hours Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) La. Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and 4 hours attending physician and I for use as the burial-transi Fall Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Dav Year isigned by the aid be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation, Hypertension Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has i performed? Yes 2 🔼 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Yes 2 No မ 1 Inpatient 2 A ER/Outpatient 3 I DOA 28a. Date of injury

'Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred ☐ Natural 5 Pending work? 1 ☐ Yes 2 🔀 No. 8/4/10 12:00 PM Trip & Fall Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Assisted Living 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9210 Kentsdale Dr. Potomac, Maryland 20854 determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Underlined Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

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8/4/

11119 Rockville Pike, Rockville, MD 20852

on who completed cause of death (Item 23a) (Type, Print)

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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 0 2010 Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

DOME

Barks

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 9, 2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Augus 2:40 ulvester, Albert Kuiawa 2010 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore VA Medical Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)

Maryland 1 🔀 M 2 🗆 F Months Days Hours Min. oct. 15, 1922 Yrs 217 16 0894 87 Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 7918 Wynbrook Rd. 21224 USA ural", or items? 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black. White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after If Yes, Give 943/1984 Year or Dates. 1 Yes 2 X No Specify: Specify: White "natural", Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Maritime Shipping permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other than injury or other traumatic event, the once. 12 Merchant Marine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Henry Kujawa Augusta A. Yorik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Kujawa (Wife) 7918 Wynbrook Rd. Baltimore, Maryland 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Inc. 8/10/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex. Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician disease or condition resulting in death) stage cor pulmonal-e years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Et let Unority by Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown g Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Director, After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes 2 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No 1 Tes မှ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 🗔 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d Date signed (Month Day, Year) 1063737518 MD August 6, 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Sarah Ciccotto

AUG 1 0 2010

31. Date filed (Month, Day, Year,

XX

ORIGINAL

Greene St

Baltimore, MD 2120

10-05923 Pegav Irene Kidd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2010 24952

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Physician			3. Time of Death
Medical Examine	- 991 ene Rida	August 7, 2010	0620 hrs
)	4a. Facility Name (if not institution, give street and number) Carroll Hospital Center 4b. City, Town, or Location Westminster	Carroll	
Funeral Director	216-90-2315 1 M XXF 46 Yrs. Months Days Hou	der 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth Foreign Cou	Maryland mtry)
nd show any sce.	Usual Residence of Decedent 10a. State		10d. Inside City Limits 1 Yes XX No
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 XXMarried Armed Forces? 1 Yes 2 XX No 1 Yes 2 XX No 1 Yes Sive Year 1 Yes XX No specify		te
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Baltimo permit. Page Department of Important: injury or oth	21. Signature of Per Some Licensee 22. Name and Address of Facil	8/10/10 Manchest Eckhardt Funeral Ch stown Rd. Owings Mil	apel P.A.
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Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune ledical Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, 6 (Specify)	etc. 28f. Location (Street and Number or Rura or Town, State)	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	1/98 (-entitler -		
To with To com	29b. Signature and title of certifier 29c. License numbe		h, Day, Year)
	30. Name and address of person who completed gause of death (Item 23a)	OCME August 8, 2010	
	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Ba	altimore, MD 21201	
State Registra			

amend #2 Per Phy G906 8/10 2010 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug 05 ,2010 Physician/ Day Month LOUISE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore र्भ HUSOITED Beiltimore N/A 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/20/1923 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F Min. Director 212-52-1577 ENGLAND Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? injury or other traumatic event, the M-dical Examiner must be Funeral items 23a 6300 RED CEDAR PLACE, #306 21209 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SAMUEL SIMMONS CHARLOTTE **MYERS** Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 ADRIENNE KOLS / DAUGHTER 11101 FALLS ROAD, LUTHERVILLE, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHALOM MEM.PARK 08/06/2010 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bowel Physician Der disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Jav 5.5 Sequentially list conditions, if any, leading to immediate Examiner Due to (or a a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? certificate 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this eted filled in by the funeral directed filled f 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2
To the F 3 and title of certifier 29d. Date signed (Month, Day, Year) NO KE2-000 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) Hospital 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State AUG 1 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

KOL

Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

John

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Klin

9000 Fran

32. Registrar's Signature

29d. Date signed (Month, Day, Year) AUGUST, 6, 2010

Drive Baltimore, MD 31237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Mar	yland .		artment of tificate of			Mental Hy	giene Reg. N	010	24955
			1. Decedent's Name (First, Min	ddle, Las	t)					_		2. Date of De			3. Time of Death
Р	hysicia Medio		Charles You	nø	Lee							Month Augus	Day 8 t 8 20	Year	9:00A M
	iviedic Examir		4a. Facility Name (if not institu			ber)			4b. City, Town	, or Location	n of Death	Augus		inty of Deat	
			195 Attenbo	rough	Drivo	Ant	103		Dan				В	alto.	
F	uneral		5. Social Security Number	6. Se	X	7. Age (I	n yrs. last l	oirthday)	If Under 1 Ye			8. Date of Bi	rth	9. Birt	thplace (State or Foreign
	irector		180-36-7036	1.2	∆ M 2 □ F	95		Yrs.	Months Day	/s Hours	Min.	March	6,1915	Ch	untry) ina
73	MC +		Usual Residence of Decedent												
ylanc	f she	ţo	10a. State 10b. Cou	nty		1	0c. City, To								10d. Inside City Limits
Mar	28a- lotifi	Director	Md.		Balto.				Roseda1						1 ☐ Yes 2 🏋 No
h the	a or be r		10e. Street and Number						10f. Zip Cod	е			10g. Citizen	of What Co	untry?
h wit	ns 2; must	Funeral	195 Attenbor	ough						237			US	A	
21215-0036 within 72 hours after death with the Maryland rolene.	If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☑ 3 ☐ Widowed 4 ☐ Divor		12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces?		lf lf	Vas Decedent o Yes, specify Co	uban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)		Black, White	rican Indian, e, etc. ian
	natu dical	Completed		dent's Ed			1.1		ent's Usual Occ		4 -6	·	16b. Kind o	f Business	Industry
21. Fin 72	Me Me	崩	(Specify only hi		College (1-	4 or 5+)	_	life. DO	ind of work dor NOT use retire	ie auring mo ed)	ost of work	ing	L .	_	
	t, the		12		6			Phys	ician				Privat	e Pra	ctice
ind filed tal Hy	even	To Be	17. Father's Name (First, Middle	e, Last)						18. Mo		e (First, Middle,		ame)	
Za Men Men	arke atic	-	Unknown									Unknown	1		
	raum raum		19a. Informant's Name/Relatio	nship (Ty)	pe, Print)				g Address (Stre						
and 2 Health	her t		Jean Tang			DTR			Dorothy	Fiel	d Roa	d Perr	-		
Baltimore, permit. Page 1 and Department of Hea	Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【 Cremati	on 3 🗀	Removal from		20b. Place ceme	e of Dispos etery, crem	sition (Name of atory or other p	olace)	١	Date			Town, State
tim Pag	tant		4 Donation 5 Othe				Вауч	riew				-2010	Balto		
3al	Impor any in once.		21. Signature of Funeral Service	e License	ee			22	Name and Add	dress of Fac	ility Sc	himunek	Funer	al Ho	me
	= 60		Ch	4	1				705 Bel					d. 21	236
	sician/ ledical	G 7).	23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or comp st only on	a. Ma	ch line. J ru	utn't	jor	r the mode of d	ying, such a	as cardiac o	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
	miner			ſ	Fail	or as a co	onsequenc	,	hirve						6 months
		Examiner	Sequentially list conditions, cause. Enter Underlying	J	5ue to (or as a co	unsaquerin	SECTION .				-			_
uted	ld ansit	ami	Cause (Disease or linjury that initiated events	1	. Chn	me	10k	isoru	conve!	Pulne	onan	1 Dis	ease	_	< years
k §	an ar rial-t	<u> </u>	resulting in death) Last		Due to (d	or as a co	onsequenc	e of):				J		l	•
760 ate be	nysici ne bu	edical			d										
687 Sertifica	ng pl	Me	IF FEMALE:										-		
Records, P.O, Box 68760 ベ The law requires that the death certificate be executed	been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2	23c. If yes, outc 1 ☐ Live E 4 ☐ Pregr 9 ☐ Unkn	Birth 2 [nant at tir	Fetal de		Ectopic pregna Other (specify)					Date of del Month	ivery Day Year
P.O.	deta	γPI	Part II. Other significant cond	litions co	ntributing to de	eath but r	not resultin	g in the ur	nderlying cause	given in Pa	rt I.	23e. Did t	obacco use co	ontribute to	the cause of death?
S. III.	sign Id be	ğ p	Hyperten	260	n							1 🗆	Yes 2 N	o 3 ☐ Pr	robably 4 Unknown
ord requ	shou	lete	Benian	PVS	state	H	10/20	rda	ophen			24a. Was	an 24	b. Were aut	topsy findings available
Vital Records, sysician: The law requires	e has	ᇤ	10010	1 , 0	,,,,,	, (~)) <u> </u>		1			auto perfo	psy ormed? 2 X No	death?	completion of cause of
Y	ificat or, pa		25. Was case referred to medic	al					26	Place of De	eath (Chacl		2 X No	1 ∐ Yes	2 🗆 No
/Ita	irect	To Be	examiner? 1 ☐ Yes 2 ☑ No	F	lospital:	nnationt	2 EB/	Outnotion				me 5 Resi		211	**************************************
o F	eral c		27. Manner of Death		28a. Date o	of injury	285	. Time of	28c. In	jury at		28d. Describe I			ny)
Paging .	e fun	icat	1 Natural 5 Per 2 Accident Inve	ding	(Monti	h, Day, Ye	ear)	injury		ork? □Yes 2[□No				
ISIC Atte	ector by th	Certificate:	3 ☐ Suicide 6 ☐ Cou	ild not be ermined	28e. Place			farm, stre	et, factory, offic	e				nber or Rur	ral Route Number,
DIVISION OF tal or Attending Phrs after death.	Pd in		12 (16		buildin	g, etc. (S	Specity)				ļ	City or Tov	vn, State)		
DIVISION OF VITAL To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certify (Check 2 Medical	ing Physi	cian: To the be	est of my	knowledg	e, death o	ccured at the tip	me, date and	d place, an	d due to the ca	ause(s) and ma	nner as sta	ited. cause(s) and manner stated.
the H pin 24	the F	Me	only one) 3 🗆 Certify	ing Nurse											
P ¥	5 00		29b. Signature and title of certi	fier			r			nse number		_	29d. Date sig	ned (Month	, Day, Year)
			MA	_		in	(yu	in	0	D56	100	>	Augu	st-c	1,2010
2			30. Name and adoress of person		ompleted cause	of death	h (Item 23a	(Type, Pr	וחנו			_0W3		111	212011
0			31 Detection Month Day Voc	ny	130	diam's	156	ry	r. Shit	e312	-,	0000	OVI V	V1)	21204
Б	Stat Registra		AUG I U 2010	De	32. He	gist ars	Signature								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar		Otato o	i wai yia		Certific		Death	Wierkarri	Reg. N	-ZUIU	24956
	Physici	an	1. Decedent's Name (First	Middle, La	,						2. Date of D Month		Day Year	3. Time of Death
	/Medi	cal	Grace 4a. Facility Name (If not in	etitution ais		ttle		4h C	ity Town o	or Location of Dea	AUB		tc. County of Deat	1, 10
	; Examir	ier	St. Abnes		SPITA				0	-more	2011		N/A	
Ĩ	Funeral		5. Social Security Number	6. 5	Sex I□M 2XDF	7. Age (In yr		Mont	nder 1 Year ths Days	If Under 24 Hr Hours Mir). (Month, D	irth Da <i>y, Ye</i> a	g. Birt	hplace (State or Foreign untry)
	Director		218-44-516 Usual Residence of Dece	2	W 2421		92 ^Y	rs.			01/16	/19		yland
	yland yland			County		10c. (City, Town	or Location						10d. Inside City Limits
	a-fsh	ctor	MD	N/A				В	altir	nore				1 X Yes 2 □ No
	ith the	Dire	10e. Street and Number				_	10f.	Zip Code			10g. (Citizen of What Co	untry?
	sath w	eral	3600 W. Fi	ankl	T				21229		(0. 11.11		U.S.A	
	fter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2	☐ Married	12. Was Dece Armed Fo 1 ☐ Yes	rces?	0.8.			Hispanic Origin? an, Mexican, Pue	rto Rican, etc.)	10-	14. Race - Ame Black, White	
036	ral", o	þ	3 € Widowed 4 □ Di		If Yes, Giv Year or D	/e		1 □ Ye	s 2 X No	Specify:			Specify: Bl	ack
5-0	72 hc 'natur	Completed	15. Do (Specify only	ecedent's E	ducation ade completed)		16a. [Decedent's U	Jsual Occup work done	pation during most of w	orkina	16b.	Kind of Business/	Industry
121	within ene.	ldmo	Elementary/Secondary (7th Grade	0-12)	College (1	-4or 5+)		iife. DO NO mest:		nd)		NT.	/A	
7	filed Hygin		17. Father's Name (First, I	/liddle, Last)		_ DO	mest.	IC	18. Mother's Na	ame (First, Middle			
<u> </u>	Aental rked o	To Be	Thomas		Lockey					Cecel	ia Te	err	V	
5	shou and N is ma	-	19a. Informant's Name/Re	lationship (Type. Print)		19b. !	Mailing Add	ress (Street			ber, City	y or Town, State, 2	Zip Code)
2	and and lealth m 27 in tr		Sylvia But		Louis	Butle	r 27	01 W	. Gar	rison				
altimore. Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparatment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Pagical Eventing must be retified at once.		20a. Method of Disposition 1 Burial 2 Cren	ation 3	Removal from	20b. ال _ J	. Place of D	Disposition (crematory n Bro emato	Name of or other pla OWN I	9°/н	Date		Location - City or	,
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110	ng Ph fter th	T:uc	27. Manner of Death	Pending		of Injury th, Day, Year)			28c. Inju Wor		28d. Describe			
Sio	tendi leath. tor: A	cati	2 Accident	investigation				М		Yes 2 □No				
LITTLE	To the Hospital or Attending Physiclan: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	4 ☐ Homicide	determined	28e. Place	of Injury - At ng, etc. (Spec	home, farn c <i>ify)</i>	n, street, fac	tory, office		28f. Location City or To			ural Route Number,
	spita hours ineral y filled		29a. Certifier 1XC	ertifying Pl	nysician: To the	best of my ki	nowledge,	death occur	red at the t	ime, date and pla	ice, and due to th	e cause	e(s) and manner a	s stated.
	the Ho lin 24 the Fu	Medical	(Check only 2 M	edical Exar	niner: On the ba	asis of examiner stated.	nation and	or investiga	ition, in my	opinion, death oc	curred at the time	e, date a	and place, and due	e to the cause(s)
_	Voith Com	Σ	29b. Signature and title of						29c. Licens			29d. [Date signed (Mont	h, Day, Year)
	h 4		1 9	M.D					V06	15861			\$ 15 110	
	3V		30. Name and address of		completed caus	e of death (Ite	em 23a) (T	ype, Print)	ED N V	DO RA	171.4.00	4	1-0 213	127
	Sta	te	31. Date filed (Month, Pay	VAN/ Xear)	32. R	egistrar's Sign	nature	NS FC	15/27	דוכו עייו	L/ INOX	-, /	mo 213	0, 1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lorraine Murphy Haskins 7:28 A M August 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunshine Acres White Hall Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 19, 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country)
Set Virginia 1 □ M 2🏗 F Months Hours Min Director 233-40-5990 86 West Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland | Harford White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4970 Jolly Acres Road 21161 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian þ 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Registered Nurse</u> U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Rosevelt Murphy Alda (unk) Surface 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick D. Haskins / Son 1622 North Bend Road, Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 8-10-10 Towson, Maryland Name and Address of Facility Comas, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery Month Dav Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 1 Yes 2 🗌 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 XOther (Specify Hospital: Assisted 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man of Death Living 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 🗆 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific DOB/6389

State Registrar 31. Date filed (Month, Day, Year)

1716 HARPORD ROMDSULTE105 PALLSTON FOR 200

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>010</u> Month Ethel Lishnoff August 8, 10:00a M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Springhouse Assisted Living Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖾 F 2/24/1918 New York Yrs 132-03-2204 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits tx☐ Yes 2 ☐ No Maryland | Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20814 4925 Battery Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗽 No If Yes, Give 1 ☐ Yes 2x No Specify. White 3 X Widowed 4 Divorced Specify Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Medical Secratary HMO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Cohen Rebecca Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6202 Singleton Place, Bethesda, Maryland Marilyn Wind, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Judean Memorial Gdns. 08/10/2010 01ney, Maryland 4 Donation 5 Other 21. Signature of Funeral S / ice Lic 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, 1091 Rockville Pike, Rockville, MO1477 20852 24a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death disease or condition Artherosclerotic Cerebrovascular Disease resulting in death) Due to (or as a consequence of) Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). Hypertension Due to (or as a consequence of) FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant 23d. Date of delivery Month Day Year contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Assisted Living

Physician/ Medical Examiner Examine and Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

must be notified

23a

ıral", or iter I Examiner n

permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or any injury or other traumatic event the Maximum.

Baltimore, Maryland 21215-0036

as the burial-trans detached eral Director; After this filled in by the funeral di

the Hospital or Attending Physician: The law requires that the death

certificate

within 24 hours a To the Funeral D

/sician/M	IF 23
by Ph	Р
eted	-
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Be	25

edical Certificate: Medical

in the past 12 months? 1 ☐ Yes 2 [※No 9 ☐ Unknown	4 Pregnant at time of death 5 Other (specify)	
art II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use o
		24a. Was an autopsy performed? 1 □ Yes 2 ☑ No
. Was case referred to medical examiner?	26. Place of Death (Check on	nly one)
1 Yes 2 XNo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 😾
Manner of Death	28a. Date of injury 28b. Time of 28c. Injury at 28c	d. Describe how injury oc

1 ∐ Yes 2 LXXNo	1 Inpatient 2 ER/Outpatient 3 D	OOA Utner: 4 Nursing H	ome 5 Residence 6 Other (Specify) Living
27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	(Month, Day, Year) injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a Certifier 1X Certifying Phys	ician: To the best of my knowledge, death occured at	t the time, date and place, as	nd due to the cause(s) and manner as stated

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occure	d at the time, date and place, and due to the o	cause(s) and manner as stated.
(Check 2 ☐ Medical Examiner: On the basis of examination and/or investigation only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death of		
29b. Signature and title of certifier DOFACP	29c. License number H45839	29d. Date signed (Month, Day, Year) August 9, 2010

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Elliot Raffel, DOFACP, 5413 W. Cedar Lane, Suite 203C, Bethesda, MD 20814

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

raig Edv			1- For State Registrar	ate of Maryla	•	rtificate o		no Mental r	R	teg. No. 20	
P Medical	hysici Exam		1. Decedent's Name (First, Middler Craig E. Lewis						2. Date of Dea Month July 31, 2	Day Year	3. Time of Death 1640 hrs
			4a. Facility Name (if not institution 41 Shipping Place #A		mber)		4b. City, Town, o	or Location of Dea	th	4c. County of E Baltimore	
	ineral rector		5. Social Security Number 219–84–4448	6. Sex 1 X M 2 F	7. Age (In yrs. I. 48	ast birthday) Yr:	If Under 1 Ye Months Da				9. Birthplace (State or oreign Many Land
and	28a-f show any l at once.	or	Usual Residence of Decedent 10a. State 10b. County Maryland Bal	timore	10c. City,	Town or Loca D	undalk				10d. Inside City Limits 1 Yes 2 No
the Maryl	23a or 28a-f sho notified at once.	Director	10e. Street and Number 41 Shipping Pla	ace Apt 12A			10f. Zip Code 2122	22	1	log. Citizen of What USA	Country?
s after death with	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at onse.	by Funeral	11. Marital Status 1 Never Married 2 Mi 3 Widowed 4 Moiv 15. Decedent's Education (Sper	arried Armed Fo	2 XX No	lf \\ 1	Yes 2 XX N		o Rican, etc.)	White, e Specify:	hite
336 thin 72 hour	ne. • than "natu [edical Exar	Completed	Elementary/Secondary (0-12)	College (1-		during m		ation (Give kind of e. DO NOT use re		16b. Kind of Busin Printing	·
1215-0 be filed wi	ental Hygie irked other vent, the M	Be		R. Lewis, Jr				В	onita Maso		
MD 2	Ith and Me n 27 is ma aumatic ev	7	19a. Informant's Name/Relations Millard R. Lewi				1989 Stewa	artstown Ro	oad Stewar	mber, City or Town, S TSTOWN, PA	17363
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7	ment of Hea tant: If ites or other tr		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Sp	ecify:			ition (Name of coner place) Fer place) Crematory		Date /7/2010	20c. Location - Cit Glen Burnio	e, Maryland
			21. Signature of Funeral Service	Hens	N	541	lame and Addres Burgee He 3631 Fall	enss-Seitz Ls Road, B	Funeral H	lome, Inc. 2 Maryland	
/M=	sician i miner		23a. Part I. Ent the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	rphine 1	Intoxic		nd Alpra:			Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause	b. Due to (or as a c.	consequence of	·):					
cuted	nd transit	I Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	·):					
60, ate be exe	ysician a burial -	Medical	X UNPENDED	AMENDED			per me	g906 8-1	7-10 vt		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed	s attending physician and for use as the burial - transit	sician/	23b. Was decedent pregnant in the past 12 months?	e 1 Live bi	int at time of dea	2 Fe	tal death 3 ner (Specify)	Ectopic pregn	ancy	23d. Date of del Month	ivery Day Year
P.O. B	ned by the detached f	by Phy	Part II. Other significant condition			esulting in the u	nderlying cause	given in Part I.			e to the cause of death?
ds, P	een sign								1 Yes		Probably 4 Unknown e autopsy findings available
of Vital Records, ng Physician: The law requir	certificate has b ector, page 2 sh	Completed	25. Was case referred to medical				20 D	e of Death (Check	1 Yes	med? deat	
Vital hysician	this certifi	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatient		Othor:		Residence 6 🗸 0	ther Scene
n of	h. : After ti e funeral	io Ei	27. Manner of Death 1 Natural 5 Pendi		Day,Year)	28b. Time of I		ıry at Work? Yes 2 ★ No		now injury occurred	
Division	ours after death reral Director: filled in by the	Certification:		tigation IIII.	7–31–1 of Injury - At ho		t, factory, office t		unknown 28f. Location (S or Town, S	Street and Number or	Rural Route Number, City
D Tospital	hours a 'uneral l'uneral l'aly filled		4 Homicide determined the determined Homicide determined the deter	ysician: To the best	reside		red at the time. d	ate and place and	41 Shi	pping Pl.	Dundalk, Md.
To the I	within 24 hours To the Funeral completely filled	Medical	one) 2 Medical Exan	niner:On the basis of and manner sta	examination ar		ion, in my opinior	n, death occurred		and place, and due t	o the cause(s)
OF	0		29b. Signature and title of certifier	Hall	2dn		29c Licens			29d. Date signed (
) De	1	- 1	30. Name and address of person of Carol Allan, MD Ass	who completed cause istant Medical E			Street, Baltim	ore, MD 2120)1		
	St Regist		31. Date filed (Month, Day, Year)	2010 32. keg	istrar's Signatur	1 hor	Ked				

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 3:46 P Mary Jane Lambert August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year 1 M 2 X F Months Days Hours Min 87 Maryland 216-16-3734 Dec Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Lutherville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Ridgefield Road 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 Yes 2 No Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. If Ves Give Specify: 3 X Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lacher Charles Taylor Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Lambert Thropp/Daughter 1715 Church Point Court, Aberdeen, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 8/7/10 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Danetjon 5 ☐ Other (Specify) cemetery, crematory or other place) Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 Bryan Clar 23a. Part 1. Ex er the isease, or complice shock, or heart failure. List only one of tions that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate se on each Interval Between Immediate C use (Fin.) disease or condition resulting in dea ue to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Month Vear Pregnant at time of death Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown

Ph sician/ Medical Examiner Examine

Physician/

Medical

10a. State

Director

Funeral

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Completed

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Examiner

Funeral

Director

28a-f show

r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

within 72 hours after death

and 2 should be filed within 72 hours afte Health and Mental Hygiene. em 27 is marked other than "natural",

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

injury or other traumatic event,

Baltimore, Maryland 21215-0036

sician and burial-trans the attending pl page 2 should certificate

Box 68760

P.O.

Records,

Physician/Medical

è

Completed

Be

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Certificate:

Medical

IF FEMALE:

Part II.

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Division of Vital

31. Date filed (Month, Day, Year) State AUG 10 Registrar

25. Was case referred to medical

5 Pending

title of certifier

Investigation 6 Could not be

determined

examiner?

27. Manner of Death

Natural

Accident Suicide

3 Suicide 4 Homicide

only one 29b. Signaty

29a. Certifier (Check

28a. Date of injury (Month, Day, Year)

(Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at

work?

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year)

6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy

28d. Describe how injury occurred

26. Place of Death (Check only one)

2 🗌 No

Other: 4 Nursing Home 5 Residence

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland	/ Depa	irtment of I tificate of I	Health a D <i>eath</i>	and Mental	Hygier Reg. I	1e2010	24961
	Physicia Medic		1. Decedent's Name (First, Middle, Las JOSEPH A. LEX	t)						of Death	Day 2010 Year	3. Time of Death 5:25 P M
	Examin		4a. Facility Name (if not institution, give LORIEN NURSING &		NTER		4b. City, Town, o		of Death		4c. County of Death HOWARD	
	Funeral Director		220-36-7316	V M 2 D E	(In yrs. last	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 2 Hours		of Birth th, Day, Year 27	9. Birth 1938 MARY	place (State or Foreign LAND
	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits
	e Mary r 28a-f notifie	Direc	MARYLAND ANNE ARU	NDEL	PASAD	ENA	1401 7: 0				1 ☐ Yes :	
	s 23a or	Funeral Director	8304 LAIKO CT.				10f. Zip Code 2112	2		_	Citizen of What Cou	•
036	filed within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	Ever in U.S. 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes 2 🛣 No Specify			an, Mexican,	gin? (Specify Yes o , Puerto Rican, etc	r No- :.)	14. Race - American Indian, Black, White, etc. Specify: WHITE	
15-0 1-0	72 hour	Completed	15. Decedent's Ed (Specify only highest gra			(Give k	ent's Usual Occup ind of work done of	ation during most	of working	16b.	Kind of Business In	
212	within 'giene.		Elementary/Seconday (0-12)	College (1-4 or 5- 2	+)		NOT use retired) RCH CHEM	IST		M	IANUFACTUF	RING
Maryland 21215-0036	be filed wit ental Hygie rked other ic event, th	To Be	17. Father's Name (First, Middle, Last) JOSEPH LEX						er's Name <i>(First, M</i>	iddle, Maide	n Surname)	
Mary	nit. Page 1 and 2 should be file artment of Health and Mental I ortant: If item 27 is marked o injury or other traumatic eve e.		19a. Informant's Name/Relationship (Ty					and Number	r or Rural Route N		or Town, State, Zip	Code)
ຜົ	of Healt of Healt fitem 2 rother		JOSEPH A. LEX, 3	· · · · · · · · · · · · · · · · · · ·	20b. Plac	e of Dispos	ition (Name of atory or other place	T	Date		AND 21122 Location - City or To	own, State
saitimore,	permit. Page 1 a Department of H Important: If ite any injury or ot once.		1 Burial 2 X Cremation 3 4 Denation 5 Other (Specification))		O CRE	MATORY,	INC	AUG. 10 2010	CA.	TONSVILLE	, MARYLAND
g	Depa Impo any i	()	21. Signatur of Funeral Service Licens			K1 42	Name and Addres RKLEY-RU L CRAIN	DDICK HWY.,	FUNERAL	HOME LEN BI	DRNIE; MD	21061
		6 V	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final	lications that caused the cause on each line.	the death. [11	the mode of dyin	g, such as c			,,,	Approximate Interval Between Onset and Death
	nysician Medical Examiner		disease or condition resulting in death)	a. Due to (or as a	consequen	1/C	JYP	Why				
		iner	Sequentially list conditions, if any leading to firm adiate cause. Enter Underlying	b. Due to (or as a	consequen	ee ofy:			/			
p.	ecuted and Il-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c	consequen	ce of):						· · · · ·
3	icate be executed physician and sthe burial-transit	edical		d								
190	certifica anding p use as t		ZOD. Was decedent pregnant	23c. If yes, outcome o							23d. Date of delive	ery
J. DOX	the death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1			Ectopic pregnand Other (specify)				Month	Day Year
ds, r.o.	quires that en signed l ould be det	þ	Part II. Other significant conditions co	ntributing to death bu	t not resultii	ng in the un	derlying cause giv	en in Part I.	1		use contribute to the	ne cause of death? bably 4 Unknown
Records,	To the hospital or Attending Fripsician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed	Hyzkans	ion						Was an autopsy performed? Yes 2 🔼 I	prior to co	psy findings available mpletion of cause of 2 No
A I Cal	s certific	To Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\overline{\lambda} \) No	lospital: 1	ut a∏EB	(Outpatient	Otho		(Check only one)	Danislanas	6 ☐ Other (Specify	
0	aing rn, h. After thi funeral (27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	28	b. Time of injury	28c. Injury work	at ?	28d. Desc		ury occurred	
IVISION OF	after deat Director; d in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		, farm, stree		Yes 2 1	28f. Locat	ion (Street a r Town, Stat	nd Number or Rural e)	Route Number,
	n 24 hours n 24 hours ne Funeral pleted filler	Medical	(Check 2 L Medical Examir	ician: To the best of m ler: On the basis of exa e Practioner: To the be	ımination an	d/or investig	ation, in my opinio	n, death occ	curred at the time, or	late and plac	e, and due to the cal	use(s) and manner stated.
1	with:		29b. Signature and title of certifier	uz	~>		29c. License	number 132	-2_	29d. D	ate signed (Month, I	Day, Year) 9/20/6
	10		30. Name and address of person who co	ompleted cause of dea	th (Item 23 4304	a) (Type, Pri	nt) NTALN	ROA	D P.49	ADEI	RA KLA	21/22
	Stat Registra	е	AUG 1 02010	32. Registrar	s Signature	par	V				-	

Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month	2010 24962
Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month	
	Day Year
Wedical =xaminer	010 0015 nrs
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital Baltimore	4c. County of Death NA
	(MM/DD/YYYY) 9. Birthplace (State or
Director 217-13-8508 1 Mm 2 F 23 Yrs. Months Days Hours Min. 11-13	
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location 10b. MD NA Baltimore	10d. Inside City Limits 1 X Yes 2 No
Toa. State 10b. County 10c. City, Town or Location Baltimore 10c. Street and Number 10c. Street and Number 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. Ci	g. Citizen of What Country?
Page 1 106. Street and Number 106. Street and Number 109 208 S. Tremont Road 21229	USA
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
11. Marital Status 1 Never Married 2 Married 2 Married 12 Was Decedent Ever in U.S. 1 Never Married 2 Married 12 Never Married 2 No	White, etc. African
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 1	SpecifyAmerican 16b. Kind of Business/Industry
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पुष्ट events resulting in death) Last Due to (or as a consequence of):	
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≥ 29b. Signature and title of certifier 29c. License number 2	29d. Date signed (Month, Day, Year)
Theoder M. Wind Thy weel)	August 8, 2010
30. Name and address of person who completed space of death (flem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State State Registrar AUG 1 0 2010 2. Registrar's Signature A. August A. August A.	

10-05924

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08 301a Louise M. McCray Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death sedale K0 saltimure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 2 Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 □ M 2 🔀 F Days Hours Min. 236-48-3337 78 Director WVA Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Baltimore Essex 1 ☐ Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 501 Riverside Road 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 0 Yes 2X No Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Roma's Waitress 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Griffith Bowman Alberta Shanholtzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald McCray 501 Riverside Road Balto. MD /son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗗 Burial 2 🗌 Cremation 3 🗌 Removal from State Holly Hill Cemetery 8/12/10 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. Die to (or as a consequence of): Medical resulting in death) Examiner umonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that introduced to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of Examine Due to (or as a consequence oi). ina Cancer the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: 은 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 Tes 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUARE DRIVE Baltimore, MD 21237 32. Registrar's Signal State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 8 per In, 8906,08/Personal of Health and Mental Hygiene 2 ()
Registrar

Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AUGUST A^{M} 2010 7:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kalti More 8. Date of Birth 0/21/1932. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🔏 F Yrs. Director show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Funeral Director Baltimore or 28a-f 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. , or Completed by 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🔀 No Specify: "natural" 3 Widowed 4 ☐ Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eone. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle မ 19a Informant's Name/Relationship (Type, Print) Son Ba 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ròad Maryland 23a. Part T. Enter the delease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. . Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ METASTATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** RENAL FAILURE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CARDIOMYOPATHY 24a. Was an has autopsy 1 ☐ Yes 2 🔼 No 1 Tyes director, To Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury s after death. 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Pract ner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 7601 OSLER DRIVE TOWSON MARY LAND KHOSROW TABASSI, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10:35 P^M MARY CATHERINE MORGAN AUG. 3, 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 521 Trimble Road Joppa 9. Birthplace (State or Foreign Country)_ If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Hours 1 □ M 2 1 F Yrs. 9, Director 1921 Maryland 89 Apr. 215-18-9717 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ XNo other traumatic event, the Medical Evan in an unstibe notified **Funeral Director** Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 521 Trimble Road 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify. þ Specify: White 3√ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George (unk) Tucholka Eva Frances Dauses ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Holcomb / Daughter 2716 Old Joppa Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any injury or conce. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp; 8-10-10 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part . Enter the disease, or complication that caused the death. Shock, or heart failure. List only one cause on each line. MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdo 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final Failure 12 cnal years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. It is continued to the cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the burial-transi BSCUD resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown COPD 24a. Was an men die

Physician /Medical Examiner

3altimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Records,

P.0.

Division of Vital

within 24 hours after death.

To the Funeral Director, Af completely filled in by the fu

Completed by Be Certification: To Medical

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3/295

Bank

29d. Date signed (Month, Day, Year)

21206

8/5/10

State Registrar

30. Name and address person who completed cause of death (Item 23a) (Type, Print) 5701 Kanword

mo K Wesz 31. Date filed (Month, Day, Year) 32. Registrar's Signature

29b. Signature and title of certifier

AUG 102010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Cortificate of Death

			For State Registrar	tate of Maryland		artment <i>tificate</i>			and Me		giene Reg. Na	Z II I II I	24966
	Physicia		1. Decedent's Name (First, Middle, Last) WAYNE FREDERICK M	TIRDHV						Date of Dea	ıth	^{ay} 2010 ^{Year}	3. Time of Death 6:10 P M
	Medic Examin		4a. Facility Name (if not institution, give street Gilchrist Hospice	and number)		4b. City, To		ocation of			40	:. County of Death	<u> </u>
	Funeral Director		5. Social Security Number 6. Sex 1私 M	2 □ F 7. Age (<i>In yr</i> s. <i>I</i> a:	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	Date of Birth Month, Day Jan 3	Year)	9. Birth Coun 1946 Mary	olace (State or Foreign to) Land
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County		, Town or Loc	ation		_	_			1	0d. Inside City Limits 1 ☐ Yes 2 🎦 No
	vith the Ma 23a or 28 st be noti	ral Dire	Maryland Harford 10e. Street and Number 106 Driftwood Cour		opa	10f. Zip 0	Code 1085				10g. Ci	itizen of What Cour	
980	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 Never Married 2 Married	Vas Decedent Ever in U.S. umed Forces? Yes 2X No Yes, Give ear or Dates.			nt of His y Cuban	panic Orig , Mexican,	in? (Specif Puerto Ric	y Yes or No- can, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	ithin 72 hour ene. • than "natu he Medical	Completed			Ìife. DO	ent's Usual ind of work NOT use n	done du etired)		of working			W Enforce	
nd 2	filed wi al Hygid d other event, t	Be	12 17. Father's Name (First, Middle, Last)		Dete	CLIVE		18. Mothe	r's Name (F	irst, Middle,			allerre
ryla	uld be d Ment marke natic e	T ₀	Harold Wayne Murphy		T			•		nmn) M			
, Ma	ind 2 sho lealth and m 27 is i her traur		<u> </u>	pouse	106	Drif	twoc				ryla	r Town, State, Zip (and 21085	<u> </u>
3altimore,	Page 1 a nent of H ant: If ite ury or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State ce	ace of Dispos emetery, crem dens o	atory or oth	er place,		Dat			ocation - City or To	
Balt	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signatur of Funeral Service Licensee	MAN		Name and CCOMA 317 C	Address S Fu okes	of Facility ineral bury	1 Home Road	e, P.A , Abin	gdo	n, Maryla	md 21009
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause (Final disease or condition resulting in death)	ons that caused the death use on each line. Due to (or as a consequence)	. Do not ente							Ì	Approximate Interval Between Opset and Death
1 P -	be executed sician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseque									
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rds, P.O.	requires that the dec been signed by the s should be detached	Completed by P	Part II. Other significant conditions contribu	ting to death but not resu	ılting in the ur	nderlying ca	use give	en in Part I.		1)X	es 2		oably 4 🗆 Unknown
Division of Vital Records,	n: The law r ficate has b n, page 2 sh		25. Was case referred to medical				00 81-	and Death	h (05-1)	24a. Was a autop perfor	SV #	death?	osy findings available mpletion of cause of
Vita	ysiciar is certii directo	To Be	examiner? 1 Yes 2 No Hospit	ial:	ER/Outpatien	t 3 🗆 DOA	Other		h <i>(Check or</i> rsing Home	e 5 🗆 Resid	ence 6	Other (Specify	Hospice,
on of	inding Phath. r: After the funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation	Ba. Date of injury (Month, Day, Year)	28b. Time of injury	M 280	c. Injury a work? 1 □ Y	at ′es 2 □ l		d. Describe h	ow injur	occurred	
Divisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	l Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Be. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory,	office		28	f. Location (S City or Tow.		nd Number or Rural e)	Route Number,
_	ne Hospit n 24 hour ne Funera pleted fille	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: O only one) 3 Certifying Nurse Pra	To the best of my knowle n the basis of examination ctioner: To the best of my	and/or investi	gation, in my	y opinion	, death occ	curred at the	e time, date ar	nd place	e, and due to the car	use(s) and manner stated.
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_	6		39 Name and address of person who comple	CRNP (1501	rint)	Cho	rks	St	TOU	Sc	n mi	21204
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2010 7:23 A M Gopaldas Jivanlal Mehta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Day, (Month, Day, 31 Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days 1**½** M 2 □ F Director 239-75-9252 71 1938 India Usual Residence of Deceder 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. **Funeral Director** 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1409 Skillman Court 21009 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: Hindu 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Hardware Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Sushila Jivanlal Parikh Jivanlal Ranchodji Mehta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr Hitesh G. Mehta / Son 1409 Skillman Ct., Abingdon, MD 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp.: 8-9-10 Towson, Maryland ²²MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE ARTERY Physician/ OROWARY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CANCER Sequentially list conditions, if any leading to keep the cause. Enter Underlying Cause (Disease or linjury Examine ending physician and use as the burial-transit VIABETES MELLI TUS. that initiated events Due to (or as a consequence of) resulting in death) Last HYPERTENTION -Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate the attending posterior IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown page 2 should be detached Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ STROKE 1 No 3 □ Probably 4 □ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, プラインショイタイ Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 NER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tiple of certifier 141080 -Chara 30. Name and address of person who completed cause of death (Item 23a) (Md. 21014 Archana CHURCHVILLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 24968 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month $20\overset{\mathrm{Year}}{10}$ William Gale Morrison 7:45 P M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3128 Nova Scotia Road Bel Air Harford 8. Date of Birth Month, Day, Yea Feb. 26, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Year) Mary Land Director 219-42-2156 65 Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 No Harford Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3128 Nova Scotia Road 21015 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Welder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev James Leonard Morrison Sally Belle Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Morrison / Spouse 3128 Nova Scotia Road, Bel Air, MD 21015 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gdn 8-12-10 Aberdeen, Maryland 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARPIAL INFARCTION Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: Exam ng physician and as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: ttending or use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the d 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION Division of Vital Records, s been signated should be Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PLABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t To the Hospital or Attending Physician: The law autopsy performed DYSHPIDEMIA this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpa within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

PULPORP, AVENE, BEZALR. MP 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

fre Nawalsonse MD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DOF096

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend item 10e per fh g906 8-16-10 vt

State of Maryland / Department of Health and Mental Hygiene

Contificate of Death 24969 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August Day 2010 Year 2:15 Рм Miller Gerard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Good Samaritan Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign July 24, 1922 1 🔀 M 2 🗆 F Mary land Director 88 217-18-9003 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Baltimore Baltimore <u>Maryland</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rita Funeral 21236 U.S.A. Road 9127 Santa 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ğ 1 Never Married 2 X Married 1 X Yes 2 No
If Yes, Give 1943–1945
Year or Dates. 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clothing Rental Uniform Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 C. Strohmer Miller Miller Marv Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236 9127 Santa Rita Road Baltimore, Maryland Margaret K. Miller Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens 8-12-2010 Timonium 21. Signature of Furtheral Serv 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Neumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 C No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Lath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Litatural injury work? 5 Pending 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of a 29d. Date signed (Month, Day, Year) 2010 nd address of person who completed cause of death (Item 23a) (Type, Print) Roven Blud ranc d (Month, Day, Year) 31. Date f 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24970 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 201 gai Ann Patricia Ам 9:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Assumpta Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F Davs Hours June 16 88 Director Eddvstone. 065-42-8267 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6401 N. Charles St. 21212 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Patrick J. May Ann G. Neary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cornelia Curran/ friend 3215 Romilly Rd. Wilmington, DE 19810 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ilchester Cemetery 8/12/2010 Ilchester, MD Signature of Funeral Service License Towson, MD 21204 Towson Funeral Home, Inc. 1050 York Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lla 121.11 Priysician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

To the Funeral Director: After this certific completed filled in by the funeral director, i within 24 hours a

disease or condition resulting in death)	a. Due to (or is a consequence of):		3 Months			
	Bad to (a) Le a dell'esquelle esq.					
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that initiated events resulting in death) Last	C. Due to (or as a consequence of):					
	- V.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1		Date of delivery Month Day Year			
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State Registrar 29b. Signatu

address of person who completed cause of death (Item 23a) (Type, Print)

MD

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atrick Louis Ma	ıxa	State of Maryland / De	•		and Mental	Hygiene		201	0 210
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		4a. Facility Name (if not institution, give street and number)	-	4b. City, Town,	or Location of Dea	ith	40	. County of Death	
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Baltimore, permit. Pages 1 an Department of Her Important: If ite		ignature of Funeral Service Licensee	1						
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or A of A of A of a of a of a of a	읣	3 Suicide 6 Could not be 28e. Place of Injury -	At home, fa	rm, street, factory, office	e building, etc.	28f. Location or Town		nd Number or Ru	al Route Number, City
Divisior Hospital or Attend 24 hours after death. Funeral Director:	Certification:	4 Homicide determined (Specify) Parking	Lot, in \	/ehicle		8214 North	Point Ro	ad, Edgemere,	MD
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To the How within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	on and/or in	vestigation, in my opini	ion, death occurred	at the time, dat	e and pla	ce, and due to the	cause(s)
FSFO	ž	29b. Signature and title of certifier		29c. Lice	ense number		29d. [Date signed (Mon	th, Day, Year)
		Alla bundle IXI		0.0	C.M.E.		Aug	ust 6, 2010	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)						
		Melissa Brassell, MD Assistant Medical Exa		111 Penn Street,	Baltimore, MI	21201			
St	ate	31. Date filed (Month, Day, Year) 32. R gistrar's Sig	nature -					-	
Regist		ALIA 4 BARLA							

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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Viola Noe1 Irene August 20 ĬT 7:40 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 561 Fairmount Road Linthicum Heights Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 F Days July 4, 1927 212-22-6002 83 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2XX No Anne Arundel Co. Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 561 Fairmount Road United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Seconday (0-12) College (1-4 or 5+) 10 yrs. Board of Education Bus Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leonard Freeman Minnie Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol N. Walker / Daughter Fairmount Road Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery Aug. 9,2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility 1 2nd Ave. SW Glen Burnie, MD Signature of Funeral Service License M01121 21061 Singleton Funeral & Cremation Services, PA. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) cestiv Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated a central cause). Examiner attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Eftal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 🖪 Residence 6 🗌 Other (Specify) 1 🗌 Yes 2 🗗 No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number DO040491

Registrar

DHMH 17 Rev 7/2009

State

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Syecl MA hi

518

32. Registrar's Signature

			For State Registrar			nd / Depa		of Healt		ental Hyg	ene	2010	24973
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-tr	Examir	ner	4a. Facility Name (If not instituti FRANKLIN 5. Social Security Number	quase	HOSP 7. Age (In yrs.		4b. City, Tov	2052	dale		13		MOFE
	Funeral Director		217-38-4479 Usual Residence of Decedent	1 ☐ M 2 ☐ X F		69 Yrs.		ays Hou	rs Min.	8. Date of Birth (Month, Day, March T) 19	4 1 Court	lace (State or Foreign try) MD
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21215-0036 d within 72 hours aft	jiene. r than "natu Inc Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12th	nt's Education est grade completed) College (1-	4or 5+)	(Give	dent's Usual O kind of work d DO NOT use re ice Cl	one during r etired)	nost of workin	g 1		of Business/Ind	
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σ _ g	f Health and Mental H item 27 is marked oth other traumatic even		19a. Informant's Name/Relation Jerry Nick On Mathed of Signature		000	504	A Hea	th A	venue	Route Number, Linth:	Lcum	MD 21	090
Baltimore,	rtment crtant: If		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (21. Signature of Funeral Service	Specify)		credHe	sition (Name of natory or other eartof Name and A	Jesu	\$ 8/1	2/10	Balt	timore	e MD
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760, te be executed	physician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	r as a conseq	,							-
the death certifical	attending p for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta ant at time of d	l death 3 □	Ectopic pregr Other (specif				23d.	Date of delive Month	ery Day Year
I RECORDS, P.O. The law requires that the	has been signed by the le 2 should be detached	ρ	Part II. Other significant condit	ions contributing to dea	ath but not reso	ulting in the ur	nderlying cause	e given in Pa	rt I.				e cause of death?
	ate	Completed			 			·		24a. Was an autopsy perform	ed?	b. Were autoprior to cordeath?	osy findings available inpletion of cause of
DIVISION Of VITA or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1	Hospital: 1 26a. Date or (Month) ng igation not be place of 28e. Place of	patient 2 f Injury , Day, Year) of Injury - At hog, etc. (Specif.	28b. Time of Injury	M 28c.	Other: 4 Injury at Work? 1 Yes 2	Nursing Hom 2	(Check only one 10	nce 6 🗆	curred	
UN the Hospital or	thin 24 hours a the Funeral D	Medical Ce	29a. Certifier (Check only one) 29b. Signature and title of certifie	ng Physician: To the ba	sis of examina	wledge, death	estigation, in i	ne time, date my opinion, cense numbe	death occurre	d at the time, da	te and plac	d manner as s ce, and due to gned (Month, i	the cause(s)
D 01	≱ ₹ 8		30. Name and addre is a person	le 20	Am of death (Item	IEC	1	169	248	29	8	9/10)
	Sta Registr	te	DR Carry San Person 31. Date filed (Month, Day, Year, AUG 102010	Samie	c 9 gistrar's Signa	000		Klin	Sau	حدد ا	ر الح	Balto	md 21237
рнмн	17 Rev 1/20		AUG T V ZUIU	phonon for	s. step a	· ·							

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For Amend Items 10e, 19b per fin 20b, per FH, G906, 8/10/2010 us state Registrar Amend Item 4a, per, fin, g906, 8/2000 tifficate of Death Reg. No. 2010 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 8:10a.M Medical Tina W. Parker 80 05 2010 4a. Facility Name (if not institution, give street and number)

Egerton **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Edgerton Road If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Year) 28 1 □ M 2 🕱 F Months Days Hours Min. 06 26 Country) Director SC 82 066-26-3970 Usual Residence of Decedent 28a-f show 10a, State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA ¥ Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Egerton 21215 U.S.A. Edgerton Road 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes W No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) Callege (1-4 or 5+) City of Baltimore Center Director 4yrs+ 2th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Parnell Fludd Simon K. Whaley 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3315 Edgerton Road, Baltimore, Md 21215 Charles T. Parker 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specify) 8/10/2010 8/9/2010 Baltimore, Md 21. Signature of Fureral Service License 22. Name and Address of Eacility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CHUCER disease or condition resulting in death) 426 Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): burialnding physician are as the burial-Physician/Medical that the death certificate be use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 1 Yes 2 Unknown P.0. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Pres 2 No 3 Probably 4 Unknown Completed EWSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 sl autopsy performed death? 1 Yes 2 No Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 4 hours after death.

**uneral Director: After this ed filled in by the funeral di this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 304 08 son who completed cause of death (Item 23a) (Type, Print) 100 million last grand is million and KERD MINEM 31. Date filed (Month, Day, Year) AUG 102010 32. Registrar's Signature State parkel Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland	/ Depa	irtment of F tificate of D	lealth and Death		jiene 2	010	24975
			Decedent's Name (First, Middle, Language)	ast)					2. Date of Dear	th		3. Time of Death
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2,000	Examin		4a. Facility Name (if not institution, give	re street and number)			4b. City, Town, or		h	4c. Cour	nty of Death	
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	Funeral Director		127-10-5439	Sex 1 □ M 2 🖾 F	e (In yrs. last 89	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth May 24,	T921		place (State or Foreign ngland
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	arylar a-fsl	Director	Maryland Montgon	ery		Bethe						1 ☐ Yes 2 ☒ No
	or 28 or 28 e noti	اقًا	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cou	ntry?
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Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ed once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		Gate	e of Dispos netery orem e of l emete:	sition (Name of atory or other plac leaven	e) Augu 20	ist 10. l	^{20c.} Location		own, State ng, Maryland
Balt	permit. Depart Import any inj once.		21. Signatu 6 u ral ce Lice		M00198	Ro	Name and Address	s of Facility umphrey	Funeral	Home/	Bethes Ch	da-Chevy lase Inc 1 20814-3501
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	Medical		disease or condition resulting in death)	a. Due to (or as a	consequen	ice of):	1	rua	tory	Jour	Me 4	
Andrew Co.	Examiner	ارا	Sequentially list conditions,	Su	ere	†	ulmo	nare	1 Hel	5 vo-	513	
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	and trans	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c Due to (or as a	consequen	noe off:						
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Box 687	requires that the death certifics been signed by the attending p should be detached for use as t		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of deliv	verv
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isic	I or Attending after death. Director: After I in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ry - At home	, farm, stre	et, factory, office		28f. Location (St.		nber or Rura	l Route Number,
	ital or irs aft al Dir led in			building, etc	. (Opeony)				City or Town	i, State)		
:	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of on hiner: On the basis of extreme the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last	amination ar	nd/or investi	gation, in my opinio	n, death occurred	at the time, date an	d place, and	due to the ca	use(s) and manner stated.
	o viii		29b. Signature and title of certifier	Luza	u	1	DOC	number 7626	54 2	9d. Date sign	ned (Month,	pay, Year) 2010
			30. Name and address of person who Angeline Lazarus		eath (Item 23 01 Wi	Ba) (Type, Pi scons	in Ave.,	Bethesda	a, Maryla	and 20	889	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year Hansel B. Pate August 2 12:55 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months October 29 1 X M 2 D F Hours Min 245-16-1602 88 South Carolina Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11803 Selfridge Road 20906 United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 X Married 1 X Yes 2 No If Yes, Give WWII Year or Dates. Korea ģ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working within 72 United States Health and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Army Medic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Peter Pate Ada Priest Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and Department of Health and Important: If item 27 is residual or or other trans Margarete W. Pate/Wife 11803 Selfridge Road, Silver Spring, Maryland 20906 Baltimore, August 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Maryland 20850 Montgomery Avenue 21. Signature of Funeral Service License M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ppysician/ Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physiciar by Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Discoid lupus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Adrenal Insufficiency this certificate has page 2 autopsy performed 2 🗌 No Yes 2 X No Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{M Other (Specify)} \) 1 \(\text{Inpatient} \) 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work 1 Yes 2 No Accident Investigation 24 hours after deatle Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kouarchou, me Jocetune D63748 August 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

6001 Muncaster Mill Road, Rockville, Maryland 20855

MD

32. Registrar's

Jocelyne Kouatchou,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Physician/ Daisy Neal Perrone 6:00 August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day,)
July 10 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 1924 South Carolina Months Days Hours Min. Year) Director 250-24-9582 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Brookeville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3345 Tanterra Circle 20833 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 🔀 No 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Kennedy Neal Daisy Hilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John K. Perrone / Son 3345 Tanterra Circle, Brookeville, Maryland 20833 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park August 11,2010 Rockville, Maryland 21. Signature of Funeral Service licensee Robert Addre FumphreyFuneral Home/Rockville, M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the bunal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy that the death in the past 12 months? signed by the atte Day Year Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be the Hospital or Attending Physician: The law requires thin 24 hours after death.
the Funeral Director: After this certificate has been sign Vital Records, Diabetes, Dementia 1 Yes 2 40 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 20 N 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending 1 Tes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioners T. the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814-1422 Babak Pirouz, M.D. 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#31perDVR, G906, 8/10/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month 20^{YP}0 11:01 PM Crystal Palumbo 4 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNIE ARUNDEL Hollywood RIVE Social Security Number 6. Sex 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 2 12-78-5572 Director Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director glen Burnie MD 1 XYes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 113 Hollywood SA U 21060 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ ODIE BYRD BONNIE YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 119 HOLLYWOOD DR., GLEN BURNIE, MARYLAND 21060 FELIX J. PALUMBO / HUSBAND Date 9 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State AUG 2010 Burial 2 ☐ Cremation 3 ☐ Removal from State GLEN HAVEN MEM. PARK Dopation 5 Other (Specify) GLEN BURNIE, MARYLAND 22. Name and Address of Facility
KIRKLEY-RUDDICK
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 21. Sign vice Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ UNG disease or condition resulting in death) Medical Due to (or as a nsequence of) 2 wtown Examiner GTASTA Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury Examine Dualty Cycles a persecutions of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Month Pregnant at time of death Dav Year To the Hospital or Attending Physician: The law requires una une with the Atlants after death.

To the Funeral Director: After this certificate has been signed by the a funeral control of the Atlanta and the Atlanta and the Atlanta and the Atlanta and the Atlanta and the Atlanta and the Atlanta and the Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and Atlanta and At 1 Yes 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier Howarth CRA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eld Rd Glan Burnie 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 0 20 State Registrar

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28tate of Mary 2966, 0899101961 Balth and Mental Hygiene 1 - For State Registrar 24979 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ Month narles John August 5 8:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Days Hours July 15 Months Director 1922 Mary Land 216-14-1200 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🏝 No Maryland Harford Edgewood ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1902 Juniper Road 21040 TISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, rmed Force: Black, White, etc. 0 1 Never Married 2 Married þ 2 No 3 Widowed 4 □ Divorced If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Lithographer Printing injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Mental Important if item 27 is many injury or other. ၀ Charles Joseph Roth Catherine Josephine Donhauser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Georgianna Hammond</u> / Daughter 11 West Orange Ct., Baltimore, MD 21234 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Garxison Forest VA Cem. 3 ☐ Removal from State 8-11-10 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate terval Retween Onset and Death Immediate Cause (Final Myocardia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) SERVICENTIAN APPROPRIE BY MEDICAL SEMINER Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day 4 Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fracture right hip 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy death? certificate ☐ Yes 2 XN To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Certificate: To 2 🗆 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural
2 Accident 28c. Injury at 28d. Describe how injury occurred Subject fell. 5 Pending 2 No August 2, 2010 1 🗆 Yes UNK 28f. Location (Street and Number or Rural Route Number, 21040 Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Mace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home 902 Junioer Rd Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as st. ted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ATTENDING PHYSICIAN

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Registrar

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Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST Ridgley 2010 Cornelia 6:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTE TOWSON BALTIMORE . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours July 31 ^{'ear}1911 1 🗆 M 2 Maryland Director 99 214-24-8605 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No N/ABaltimore Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 U.S.A. 3506 Courtleight tems 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. ö Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harts Emily Daniel Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtleight Dr, Baltimore, Md. 21244 Arthur Ridgley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Western Star Cem. 8/12/10 Catonsville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Ser, P. A. 1300 Eutaw Place, Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the prode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 No 9 Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably # ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an after death.

Director: After this certificate has d in by the funeral director, page 2 s 1 ☐ Yes 2 ☐ No Yes P N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 Hospital Other: 1 🗌 Yes Certificate: To ↑ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital o within 24 hours af To the Funeral D Medical 💶 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature dire fute ppleted dause of death (Item 23a) (Type, Print) 208 Towson MDD1201 1501056 re MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ Richards 6:10A 8 O Derek Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Blue Point Nursing, LLC Baltimore 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Baltimore, Md Min 1 Q M 2 □ F Director 44 215-74-4480 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 XYes 2 ☐ No Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37 Tahoe Ct 2111712. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1X Never Married 2 Married Completed by ☐ Yes Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Janitor Service Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carnel1 Richards Eleanor Dorsev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Old Court Road, Baltimore, Maryland 21208 Eleanor Dorsey Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-10-10 Catonsville, Md. Signature of Funeral Service Licenses Estep Brothers Funeral Ser, P.A 1300 Eutaw Place, Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one caus — each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours at er death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 🗗 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 43375 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

WELUUTT

31. Date filed (Month, Day, Year)

2835

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $20 \mid 0$ For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 07 2010 10:50 A M Physician/ ROZETTI MARKUS Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE RANDALLSTOWN SEASONS HOSPICE @ NORTHWEST HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex Country) UKRAINE 5. Social Security Number 1 X M 2 🗆 F Days Hours 1270871931 **Funeral** 78 214-90-5564 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marked once. 10b. County 10a. State Director 1 🗌 Yes 2 😾 No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21208 47 STIRRUP COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2X Married Be Completed by WHITE 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) METAL MACHINIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN ပ္ ROZETTI **ABRAM** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 47 STIRRUP COURT, BALTIMORE, MD POLINA ROZETTI/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 XBurial 2 Cremation 3 Removal from State REISTERSTOWN, MD BALTIMORE HEBREW CEM 08/09/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Mark 60 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line whopathe Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and list in double as Due to (or as a consequence of): Exami use as the bunal-transit and Due to (or as a consequence of) resulting in death) Last certificate has been signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month Year 4 Pregnant at time of death
9 Unknown in the past 12 months? fo 1 Yes 2 No page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Saknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical To the Funeral Director: After this certific completed filled in by the funeral director, Be 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Sther (Specify) (Mahu + Other: examiner' 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 횬 1 Tyes rospice 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: iniury work' Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 6 Could not be Suicide determined City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a

To the Funeral Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Da7683 Mule Mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21209 Sinke 203 Balhmore MD 2835

Registrar

Smith

32

Mille

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ A M Richmond Legin 9 August 2:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 3117 Liberty Parkway Dundalk If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Hours (Month, Day, Year) May 9, 1923 Director 403-26-2720 Kentucky 87 Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any pine. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 3117 Liberty Parkway 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Metallurgist Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Richmond Martha Prewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Richmond wife 3117 Liberty Parkway, Dundalk, Md. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 12. 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Oak Lawn Cemetery 2010 Dundalk, Maryland . Signature of Funeral Service Licensee ^{22, Name and Address of Facility} Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the dis ese, shock, or heart failure. r complications that caused the deat () o not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. nterval Between Immediate Cause (Final nnon and Death Physician/ disease or condition Medical resulting in death) Due to (or a Examiner Sequentially list conditions, Examiner ii any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed 2 🗌 No 1 🔲 Yes Be 25. Was case referred to edical 26. Place of Death (Check only one) Hospital Other: 뎯 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manney f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No М within 24 hours after death To the Funeral Director: △ Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The declaration of the decision 9b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State
Registrar

DHMH 17 Rev 7/2009

30 Name and address of person who of mpleted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08-03-2010 **Physician** Elfriede O. Sunder /Medical Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examiner Air Health and Rehabilitation Center 9. Birthplace (State or re-Country) Germany 8. Date of Birth 12-13-1920 If Under 1 Social Security Number Age (In yrs. last birthday) (State or Foreign **Funeral** Days Months Hours 1 □ M 2 🛛 F 89 216-36-8698 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exempter must be notified at 1 ☐ Yes 2 No Harford Bel Air Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 300 Ring Factory Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 X No Specify Specify: White 2 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johann Hermann Ottilie Sichling ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar 228 Crowl Rd Airville, PA 17302 Paul Sunder (Son) Item 27 Baltimore, permit. Pages 1
Department of Hi
Important: If Iten
any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 08-05-2010 Baltimore, MD 21. Signature of Funer 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events attending physiclan and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform After this certificate 1 ☐ Yes 2 No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 Mo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D565 45

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 1 0 2010

7 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHILPI KHOSLA 615 W, MACPHAIL RD #106, BEL AIR

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			For State	State of Maryla		irtment of I tificate of L				
	Physicia	ın/	Registrar 1. Decedent's Name (First, Middle, L	.ast) S RODNEY STANLI		inouto or i	Journ	2. Date of Dear	2010 Year	3. 2m + 1 part 5 5:52P M
	Medic Examir	cal	4a. Facility Name (if not institution, g	ive street and number)	-		r Location of Death	Aug 8,	4c. County of Death	
	Funeral		515 Orkney Road 5. Social Security Number 6	Sex 7. Age (In vrs	. last birthday)	If Under 1 Year	more City	8. Date of Birth	N/A 9. Birth	nplace (State or Foreign
	Director		218-78-2805 Usual Residence of Decedent	1 X M 2 □ F 52	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar 20,	1958 Mar	yLand
	iryland a-f shov ied at	ctor	10a. State 10b. County		City, Town or Loc					10d. Inside City Limits 1X Yes 2 □ No
	the Ma a or 28¢ be notif	al Dire	Maryland N/ 10e. Street and Number		BS	10f. Zip Code			10g. Citizen of What Cou	
	eath with	Funeral Director	515 Orkney Road	12. Was Decedent Ever in U	J.S. 13. V		21212 Hispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No-	USA 14. Race - Amer	
336	s after d al", or if Examine	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates,	I	Yes 2 X No		rican, etc.)	Black, White Specify: Wh	ite
15-0	72 hours "natur ledical I	Completed	15. Decedent's (Specify only highest	Education -	(Give I	ent's Usual Occup ind of work done O NOT use retired)	during most of workir	ng	16b. Kind of Business I	ndustry
212	within ygiene.		Elementary/Seconday (0-12)	College (1-4 or 5+) 4		tnership	owner		Bar &	grill
land	I be filed fental H rked ot tic even	To Be	17. Father's Name (First, Middle, Las Charles Pardue	,			18. Mother's Name Hope Mi		Maiden Surname)	
Maryland 21215-0036	2 should th and N 27 is ma trauma		19a. Informant's Name/Relationship Hope M. Schoedi		.				City or Town, State, Zip	
	e 1 and t of Heal If item 2		20a. Method of Disposition	20b	. Place of Dispo	sition (Name of natory or other place	ce)	ate	ksonville, 20c. Location - City or	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Signature) 1 Fune ☐ Service Lice	1			tory 8/10		Baltimore, HOME, INC.	
Ä	permi Depar Impor any ir	6 0		wson		OO York	Road, Bal	timore.	Maryland /	1212 Approximate
	ęnysician/	02 (6	shock, or heart failure. List only Immediate Cause (Final disease or condition	y one cause on each line.	fAF)	c Ma	95 Fate	_	Jac	Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	1				
	ed sit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a conse	equence ot):					
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3760	ficate be g physic as the bi			d			-8			
Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours a ler death. To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live Birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 🗌	Ectopic pregnan Other (specify)	су		23d. Date of deli Month	ivery Day Year
P.O.	s that th gned by be detac	þ	Part II. Other significant conditions	s contributing to death but not r	esulting in the u	nderlying cause gi	iven in Part I.		bacco use contribute to	
ords,	require been si should t	Completed						24a. Was a		opsy findings available
Rec	The law cate has page 2	Comp						autop perfor 1 🗆 Yes	med? death?	completion of cause of
Vital	iysician: is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	☐ ER/Outpatier	Oth	lace of Death (Check ner: 4 \square Nursing Ho		ence 6 Other (Speci	ify)
n of	ding Ph th. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injui worl M 1	ry at k? I Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division of Vital Records,	l or Atternation as er deconomic by the	Certificate:	3 Suicide 6 Could no 4 Homicide determine	t be 28e Place of Injury - At		et, factory, office		28f. Location (S. City or Town	treet and Number or Rur n, State)	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours a fer det th. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Exa	hysician: To the best of my kno aminer: On the basis of examina urse Practioner: To the best of	tion and/or invest	igation, in my opini	ion, death occurred at	the time, date ar	nd place, and due to the o	cause(s) and manner stated.
_	To the within To the compl	Σ	only one) 3 L Certifying N 29b. Signature and title of certifier	Stoch 10	Thy knowledge, c	29c. Licens			29d. Date signed (Month	
0			30. Name and address of person wh		em 23a) (Type, F & Semir	rint)	s., Luther	ville,	MD 21093	
ا	Sta Registr		31. Date filed (Month, Day, Year) AUG 10 2010	32. Registrar's Sig						-
DH	MH 17 Rev 7/2	-	AUG 2 0 2010	(Reserve)	garla					
h					ORIGII	VAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Daryll Still		or State	St	ate of Ma	aryland .	•	ment of <i>icate of</i>	Health ar Death	nd Mer	ntal Hyg			010	24986
Physician	Regi	strar ecedent's Name	e (First, Midd	le,Last)							Date of Death			3. Time of Death
Medical Examine	er D	arvll			Rica	cdo		Still		P	Month Nugust 4, 2	Day 2010	Year	0929 hrs
		acility Name (in Bon Secour		on, give street a	and number)	53(F)		b. City, Town, o Baltimore	r Location	of Death		4c. Co	ounty of Death	_
Funeral	5. S	ocial Security N	umber	6. Sex	7. Ag	e (In yrs. last I	oirthday)	If Under 1 Yea	_		. Date of Birti	h(MM/DD/	YYYY) 9. Birt Foreig	hplace (State or
Director	21	4-62-5	301	¾ ¾ M 2	F	55	Yrs	Months Day	ys Hours	s Min.	06 09	9 5	5 Cou	untry) VA
Ţ	Usu	al Residence of	Decedent					· /						
w an	10a.		10b. County	NT 71		10c. City, Tov		imore						10d. Inside City Limits 1X Yes 2 No
Aaryland 28a-f show any Latonce.	<u> </u>	MD		AV			Dalu							
Mary r 28a ed at	10e. ا	Street and Nur	nber					10f. Zip Code			10	g. Citizen	of What Coun	try?
th the 23a o notifi	39	15 Bat	<u>eman</u>		. B l	English II O	140.14-		216				U.S.	
r death with the Maryland or items 23a or 28a-f sh must be notified at onc	1 1	Marital Status Never Marrie	ed 2 M	arried Arr	as Decedent med Forces?			s Decedent of Hi es, specify Cuba					White, etc.	can Indian, Black,
her de		Widowed	4 Div	orced If Yes, G	ive Year	K No	1	Yes 2 No	specify.	:		Spe	ecify: B	lack
ours after al"		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dor during most of working life. DO NOT use retired)							of Business/Ir					
9500-15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 17. Father's Name (First, Middle, Last)							_	_			1			le Comm.
5-0036 ited within 7 Hygiene. I other than the Medica	12	th gra			ıa		Jani	toral				Coll		
11215-0036 Id be filed within 72 hours after death with the Maryland Mental Hygiene. narked other than "natural", or items 23a or 28a-f shoevent, the Medical Examiner must be notified at once. O Be Completed by Furneral Director	ather's Name (st, Middle, M	laiden Surr	name)				
2121 nould be fil d Mental I is marked tic event,	19a.	hn T. Informant's Na	Stil me/Relations	hip (Type, Prin	nt)	Ţ.	19b. Mailing	Address (Stre		a Swa		ber. City or	r Town. State.	Zip Code)
MD and 2 shouth and m 27 is aumatic	Ste	phanie	sti	ll Bel	.1-Da			•						d 21216
e, had I and Healt Healt item	20a.	Method of Disp	osition			20b. Plac		tion (Name of ce	metery,	Da	ate	20c. Loca	ation - City or	Fown, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Filmeral Director	1	Burial 2 ∑ Donation 5		n 3 Rem	oval from Sta		n-Sit			8/7/2	2010	Bal	timor	e, Md
altii mit.] partm porta ury o	21.5	Signatur of Fur			7		22. N	ame and Addres	s of Facility	y				
m 5215		wary	AUD		ranc	im	1 Ma 43	rch F/ 00 Wab e mode of dying	п we ash	Ave,	Balt:	imor	e, Md	21215
Physician /Medical	23a.	Part I. Enter the failure. List only	e disease, or y one cause	complications on each line.	that caused	the death. Do	not enter th	e mode of dying	, such as c	cardiac or res	spiratory arre	st, shock, o	or heart	Between Onset and
Examiner		ediate Cause (F andition resultin					heros	cloetic	card	liovas	cular	disea	ase	Death
1975 3 9				b Due to (c	or as a conse	equence or):								
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ted Insit	(Dis	se. Enter Under ease or injury that of ts resulting in c	nat initiated	c. Due to (c	or as a conse	quence of):								
iO, e be executed ysician and burial - transit		ns resulting in c	Jeanny Last	d										
(0, e be executed ysician and burial - transi	X	UNPENDED		AMEN	23a,27	,per M	IE g90	8 10/21	/10 T	T				
68760 ertificate b ding physie e as the bu	IF FI	EMALE: Was decedent p	oregnant in th	23c. l	f yes, outcom	ne of pregnand	су						ate of delivery	
certif	3	past 12 months		'	Live birth Pregnant at	time of death	- =	al death 3 ner (Specify)	Ectopic	c pregnancy		Mor	nth D	ay Year
Box 6876 he death certificate true attending phy hed for use as the b	1 [Yes 2 N	o 9 Unl	(DOUID	Unknown		J _ Ou	ier (Opecny)						
Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beledical Certification: To Be Completed by Physician/Meledical Certification:	Part	II. Other signif	icant condit	ions contribu	iting to death	but not result	ing in the u	nderlying cause	given in Pa	art I.				he cause of death?
ords, P.C w requires that as been signed is should be deta											1 Yes		3 Prob	ably 4 🗸 Unknown
ords w requisites been should											24a. Was ar autops			opsy findings available ompletion of cause of
Records, The law requires ficate has been signage 2 should be Completed											perform 1 Yes 2		death? 1 ✓ Yes	s 2 No
Division of Vital Records, P.O. rat or strending Physician: The law requires that the state death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director. Be Completed by Perfification: To Be Completed by Perfigure and present the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the		Vas case referre	ed to medica					26 Place		(Check only	one)	1		
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n of ding Ph. After t funeral	27. N	Manner of Death Natural			Date of Injui (Month, Day,Ye	ry 28t ear)	o. Time of Ir		ry at Work	. 1	l. Describe ho	ow injury o	ccurred	
isior Attend rector: by the	2	Accident		stigation	Discount les	21 12 22	f		Yes 2		1 1: (0:			15 1 1 1 6
Division of spiral or Attending I tours after death. neral Director: After filled in by the funer Certification:	3 [Suicide		d not be	ecify)	ury - At nome,	rarm, stree	t, factory, office t	oullaing, et	tc. 281.	or Town, Sta		number or Rur	al Route Number, City
Di Lospital 4 hours a 'uneral I thy filled		Homicide Certifier ₁	Certifying Pl		-	knowledge o	leath occur	ed at the time, d	ate and nis	aca and due	to the cause	(s) and ma	onner as state	d
To the Howithin 24 h. To the Funcompletely	one)	in only		miner:On the I	-			on, in my opinior						
Z Z Z Z	29b.	Signature and t	title of certifie		mici stated.	1		29c. Licens	se number			29d. Date	signed (Mon	th, Day, Year)
		(Oc. 1 1	111	111	19	-/-	7/	O.C.	M.E.			August	5, 2010	
R/		lame an addre	•					-						
		abiullah Ali		Assistant M			111 Peni	Street, Balt	imore, N	MD 21201				
State Registra	-	ate filed (Month	n, Day,Year) UG 1 (32. Redistrar	s Signature	1	Kel		Me.				
DHMH 17 Rev 1/2001			VV I		- Comment	~	RIGINAL	-					-	
00115 0000						U	MAIION						OCME	

10-05871	
Reginald Stovall	

teginald Stovall	I	State of Maryland / Department - For State Certificate	of Health and Mental F	Hygiene	2010	2498
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	OI DOUIT	Reg 2. Date of Death	. No.	3. Time of Death
Medical Exami		Reginald Stovall	Tarana and an analysis	August 5, 2		1729 hrs
		Facility Name (if not institution, give street and number) St. Agnes Hospital	4b. City, Town, or Location of Deal Baltimore	th	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hi		(MM/DD/YYYY) 9. Bird	
Director		220 01 1000 4 0	rs. Months Days Hours Mi			Ttimore
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
<u> </u>	J.	Md. N/A Baltimo	ore			1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	itry?
ith the 123a or 100tifie		4706 Frederick Ave. 11. Marital Status 12. Was Decedent Ever in U.S. 113. V	21229 Vas Decedent of Hispanic Origin? (S	Cassifu Vos or No	U.S.A.	can Indian, Black,
leath w	Funeral		Yas Decedent of Hispanic Origin? (S FYes, specify Cuban, Mexican, Puert		White, etc.	zan indian, biack,
after da	by F	Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify:		Specify: B1	ack
hours "natur			ent's Usual Occupation (Give kind of most of working life, DO NOT use re		6b. Kind of Business/li	ndustry
036 thin 72 ne. • than	ompleted		k-Lift		Operator	
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	ပ	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
2121 buld be fill Mental I. marked ic event, j	o Be	Frank Stovall 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Doreating Address (Street and Number or		ovall	Zin Codo)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	۲		6 Frederick Av			
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumatic			osition (Name of cemetery,		20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Western	Star Cem. 8/1	L1/10	Catonsvi	lle,Md.
Baltimore, ML permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other traum		21. Sig aftire of Funeral Service Licepsee 22.	Name and Address of Facility step Brothers	1300 Eu	taw Plac	e,BaltoMd
Physician	\exists	23a. Part I. Enter they sease, or complications that caused the death, Do not enter failure. List only one cause on each line. Liver cirrhosis				Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a. atherosclerotic car	diovascular dise	ase		Between Onset and Death
μ=λαι·····ιοι		or condition resulting in death) Due to (or as a consequence of):				
	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				_
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
recuted		d				
O, be exe sician ourial -	edical	X UNPENDED AMENDED 23a,PII,27,per ME	g909 11./1/10 TT			
Ox 68760, eath certificate be attending physic for use as the bur	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month Di	ay Year
Box 6 death cer the attendi	sicia	Pregnant at time of death 5	Other (Specify)			
D. B. trhe de by the ached f	된	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to t	ne cause of death?
ries that the signed b	d by	CHronic alcoholism		1 Yes	2 No 3 Proba	ably 4 🗸 Unknown
w requi	olete	1		24a. Was an autopsy		opsy findings available ompletion of cause of
Recc The lar cate ha	Completed			performe 1 V Yes 2	ed? death? No 1 ✓ Yes	2 No
tal Recicion: The certificate rector, page	8	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient	26.Place of Death (Check			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Function: The law requires that the death certificate be executed Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - trans	£.	1 ✓ Yes 2 No lipatient 2 ✓ ER/Outpatier 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 ✓ Notice 28b. Time of (Month, Day, Year)		ng Home 5 Re 28d. Describe how	sidence 6 Other:	
on (tending eath.	Certification:	Pending 5 Pending	1 Yes 2 No			
Division ospital or Attendii hours after death.		3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Stre	eet and Number or Rura	al Route Number, City
Ospital hours aneral		4 Homicide determined (Specify) 29a. Certifier 4 Certifier Physics Table 1 (Specify)				
To the Ho within 24 P To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investign				
F. 2 E 8	ŝ	and manner stated. 29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mont	h, Day, Year)
		Theodore Mr. King The und	O.C.M.E. OCME		August 6, 2010	
Dr sent		30. Name and address of person who completed cause /j/ eath (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimore	e MD 21201		
ly A	10	31. Date filed (Morn Day Year) 32. Registrar's Signature	on onoci, baininon	J, 1110 Z 1201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 24988 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 07 Pay 2010 5:15 A M LEONARD SILVER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE ENVOY OF PIKESVILLE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1070771916 Director 93 216-03-4160 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Tes 2 T No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 130 SLADE AVENUE, #617 21208 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner muonce. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1XXYes 2 No
If Yes, Give Black, White, etc. ۾ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTANT ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LENA RUBENSTEIN SAMUEL SILVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 SLADE AVENUE, #617, BALTIMORE, MD BEVERLY SILVER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEBREW FRIENDSHIP CEM 08/08/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Matt Cen 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ alhers dean's aniovasular des euse disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE:

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year	
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check	k only one)
examiner? 1 Yes 2	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Other: Other:	ome 5 Residence 6 Other (Specify)
27. Manner of Death 1 Aatural 5 Pending 2 Accident Investiga	(Month, Day, Year) injury work? tion M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e Place of Injury - At home form etreet factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4768

MD

29d. Date signed (Month, Day, Year)

29c. License number

၉

Certificate:

Medical

29a. Certifier

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) State Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

n 24 hours after de e Funeral Directo eleted filled in by the

within 24 ho

To the Fune

completed f

10-0566 <i>7</i> Emmanuel Duan	te 1	Please Type or Print in Black Indelible Ink. Er State of Maryland / Department of Healt		
		1- For State Certificate of Death Registrar		Reg. No.
Physicia Medical Examii		1. Decedent's Name (First, Middle,Last) EMManuel Thomas	Mont	of Death th Day Year 29, 2010 3. Time of Death 0045 hrs
		4a. Facility Name (if not institution, give street and number) 200 Block of East Lafayette Avenue 4b. City, To	own, or Location of Death Ore	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	Davis Hause Min	te of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Mary land
e Maryland or 28a-f show any fied at once.	tor	Usual Residence of Decedent 10a. State 10b. County Maryland NA 10c. City, Town or Location	Baltimore	10d. Inside City Limits 1 Yes 2 No
the Mary Sa or 28a	Director	10e. Street and Number 535 W. Hoffman St.	21201	10g. Citizen of What Country? USA
fter death with the Maryland I", or items 23a or 28a-f sho ter must be notified at once.	y Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify 1 Yes 2 No	t of Hispanic Origin? (Specify Ye Cuban, Mexican, Puerto Rican, e No specify:	
imore, MD 21215-0036 Pages I and 2 should be flied within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23s or 28s-f short or other traumatic event, the Medical Examiner must be notified at once	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	occupation (Give kind of work doning life. DO NOT use retired)	e 16b. Kind of Business/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Fleath and Mental Hyggene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	To Be Com	17. Father's Name (First, Middle, Last) Abdullah Thomas	18.Mother's Name (First, M	Johnson
ore, MD 21 ss I and 2 should of Health and Me friem 27 is ma friem 27 is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address 19b. Mailing Address 20a. Method of Disposition 20b. Place of Disposition (Nam	offman St.	Buttimore, Maryland 120c. Location - City or Town, State
Baltimore, permit. Pages 1 as Department of He. Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	tery 8/7/1	a Battimore, Maryland
		devin farker 3572	Address of Facility of ex	Baltimore, Maryland
Physician Ludicul Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds	dying, such as cardiac or respira	tory arrest, shock, or heart Between Onset and Death
	L	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last		10-0
executed an and all - transi	ical E)	d amended		
	Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
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ires that the signed by	à	Part II. Other significant conditions contributing to death but not resulting in the underlying	3	e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
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fital sician:	o Be (examiner? Hospital: 4 Innations 3 EB/Outnations 3 DO	3. Place of Death (Check only one Other Nursing Home) 5 Residence 6 ✓ Other: Scene
on of Vi-	\vdash	27. Manner of Death 1 Natural 5 Pending Pending 28a. Date of Injury 28b. Time of Injury 0035 hrs	Bc, Injury at Work? 28d. De	escribe how injury occurred ct shot
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Sidewalk		cation (Street and Number or Rural Route Number, City Town, State) ock of East Lafayette Avenue, Baltimore, MD
o the Hosp ithin 24 ho o the Fund ompletely f	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the one) Wedical Examiner: On the basis of examination and/or investigation, in my and manner stated.	ime, date and place, and due to the opinion, death occurred at the time	he cause(s) and manner as stated. e, date and place, and due to the cause(s)
E & E 8	Me		C.C.M.E.	29d. Date signed (Month, Day, Year) July 29, 2010
8		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, E	altimore, MD 21201	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :42 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hooking HIMONE If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🖳 Hours Min. Month, Day, Country) Director Yrs. Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 1 ☑ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ₩idowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ manue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other page 200). 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service License Services 21133 au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (o as a consequence of) Examiner Wee Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed ause (Disease of imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 2 No page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has I autopsy perform 2 2 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗓 မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural 5 Pending 2 🗌 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 08.06.2010 30. Name and address of person who completed e of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Himore 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month Bay, Months Days Min. **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No more 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No 3 Wildowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. econday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Typ Page 1 and 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other Method of Disposition Burial 2 Cremation 3 Removal from State 4 Other (Specify) Signature of Funeral Service Licensee No 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Approximate Interval Between Onset and D ath shock, or heart failure. List only one cause of each line Immediate Cause (Final Physician/ Cystic Caranomy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one egistrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 21:00 PM Andrew Tsamoutalis 2010 Medical 4500 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Johns Hopkins Bayview Medical Cente If Under 1 Year If Under 24 Hrs.

Pays Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months February 29, 1936 Director 212-36-1264 Greece Usual Residence of Decedent or 28a-f show notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
and: If item 27 is marked other than "natural", or items 23a or 28a-f sho usy or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 USA 346 S. Newkirk Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 XYes 2 No
If Yes, Give 1 √ Never Married 2 ☐ Married ρ Maryland 21215-0036 Spe**White** 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore 8 years Social Worker <u>12 vears</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Fournaris Stephen N. Tsamoutalis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4311 Edro Avenue, Nottingham, Maryland Brother James Tsamoutalis permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tu once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 10, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Amunciation Cathedral Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 7110 Sollers Point Road, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardiac Physician/ PEA week disease or condition Medica! resulting in death) Due to (or as a consequence of) Examiner Sepsis reek Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-transit Multi-10bar Preumonia weeks that initiated events Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes_ 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** æ Other: 1 Tyes 2 🔀 No 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ceatin occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check To the I within 2 only one) 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

4940

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Res-000

Eastern Avenue

Battma

2010

State
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6 2010 Bernadette M. Vetter 5:15 PM August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore John Hopkins - Bayview If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year)
Dec. 8, 194 Days Min. 1 M 2 XF Hours MD Director 217-38-7391 67 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Baltimore Baltimore 1 ☐ Yes 2 🛣 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21224 6403 Danville Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2x No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker GM 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F ပ္ Bernadette M. Rauh Franklin F. Kuyawa Health and Ment item 27 is marked other traumatic e 19a. Informant's Name/Relationship (Type, Print)

Bernadette **Kuyawa** / mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 183 Bennett Road Baltimore MD 21221 Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State of SacredHeartofJesus 8/11/10 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final CORONDRY ANTEKY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 2007 **Examiner** MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) HUPERUPIDIMIA Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last HUPERTENSION Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🌠 No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be or 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Newropalhy Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 NOA မ Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 Natural Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 041496 5 aba Seddigi

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 0 2010

SABA

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SIDDI 0-1

9106

PHILA- RD SUITE #204, BALTO MD 21237

10-05810 Larry Wright

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2010 24994

		1- For State Registrar	Cert	ificate of E	Death		Re	eg. No.	
	n/	Decedent's Name (First, Middle,Last)					Date of Deat Month	Day Year	3. Time of Death
Medical Examin	ner		VARD WRIGHT		Oit Town	1	August 3,	2010 4c. County of I	0532 hrs
		4a. Facility Name (if not institution, give street Johns Hopkins Hospital	et and number)		City, Town, or Baltimore	Location of	Deatti	N/	
Funeral		Social Security Number	7. Age (In yrs. las	st birthday)	If Under 1 Yea	r If Under 2	24Hrs. 8. Date of Birt	th(MM/DD/YYYY)	9. 8irthplace (State or
Director		214-64-5911 ¹ XM	2 F 4.6	Yrs.	Months Day	s Hours	Min. 09/26/		oreign MARYLAND Country)
	1	214-64-5911 1 X M Usual Residence of Decedent	² 46				09/20/	1905	
v any		10a. State 10b. County	10c. City, T	own or Location					10d. Inside City Limits
land f shov	5	MARYLAND N/A			TIMORE				1 X Yes 2 No
Mary r 28a- ed at	Director	10e. Street and Number		1	Of. Zip Code		10	og. Citizen of What	Country?
11215-0036 The filed within 72 hours after death with the Maryland dental Hygiene. The filed with an "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	ᇍ	530 N CHESTER ST.	Mar Daniel Translatt 0	140 14/22 5	2120		2 / Sasait Vacan No.	U.S.A.	American Indian, 8lack,
ath writems	Funeral		Was Decedent Ever in U.S Armed Forces?				? (Specify Yes or No- Puerto Rican, etc.)	White, e	
iter de		3 Widowed 4 Divorced If Yes	∫ Yes 2 XXNo , Give Year	1 Y	es 2 X No	specify:		Specify: BI	ACK
ours al atural	g p	15. Decedent's Education (Specify only hig	hest grade completed)	16a. Decedent's	Usual Occupation			16b. Kind of Busin	ess/Industry
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within giene.	E I	12yrs 17. Father's Name (First, Middle, Last)	2yrs	ELECTI		18 Mother's	Name (First, Middle, M	BOGMON	INC.
21215-0036 vald be filed within 7 Mental Hygiene, marked other than event, the Medical event, the Medical	BeC	ELMER EDWARD WRIG	איר דפ				HERINE THO		
212 vuld bo Ment mark	2	19a. Informant's Name/Relationship (Type, F		19b. Mailing A	ddress (Stree		er or Rural Route Num		State, Zip Code)
MD td 2 shc 2 shc and 2 shc and 2 shc and 27 is aumati		Sharon Y. Wright/Wi	fe	530 N	. Chest	er St	., Baltimo	re, Maryl	land 21205
re, land freal freal freal freal freal freal freal free er tra	1	20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	20b. Pl	ace of Dispositio		metery,	Date	20c. Location - Ci	ty or Town, State
Page Page nent o ant:		4 Donation 5 Other Specify		NG MEMO	RIAL PA	ARK (08-13-10	BALTIMO	ORE, MARYLAND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	1	21. Signature of Funeral Service Acer see		22. Nam WIL	ne and Address LIAM C	s of Facility BROWN	COMMUNITY	FUNERAL	HOME P.A.
	-1	23a. Part l. Enter the disease, or complication		j 120	6 W NOF	RTH AVI	ENUE		Approximate Interval
Physician I	d	failure. List only one cause on each line	Э.		mode of dying,	ouer do care		,	Between Onset and Death
Examiner			nonary Thromboemb o (or as a consequence of):						
		Sequentially list conditions, b							
	Examiner	cause. Enter Underlying Cause	(or as a consequence of):						of the second
- H	xan	(Disease or injury that initiated events resulting in death) Last	(or as a consequence of):						
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O, e be ex sician sician burial	Medical		ENDED					100 0 1	
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Box 687 te death certific the attending judd for use as the	/sician/	past 12 months? 1 Yes 2 No 9 Unknown	Pregnant at time of deat	h =	(Specify)			E.	l
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Division of Vital Records, P.O. Box tall or Attending Physician: The law requires that the death its after death. al Director: After this certificate has been signed by the arte led in by the funeral director, page 2 should be detached for	≦	Tarrii. Other organicant contains	butting to death but not res	alting in the una	criyinig oddoo g	givon in r unc		2 No 3	
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ivis or At after d Direc	<u></u>	3 Suicide 6 Could not be	8e. Place of Injury - At hon	ne, farm, street, f	actory, office b	ouilding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
D sspital hours meral y filled		29a Certifier	(Specify)						
Division of Vital Records, P.O. B within 24 hours after death. To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	(Check only	o the best of my knowledge ne basis of examination and						
To with To com	Med.	and r 29b. Signature and title of certifier	nanner stated.	<u> </u>	29c. Licens	e number		29d. Date signed	(Month, Day, Year)
		- Santile Rivithell.	MI		O.C.I	M.E.		August 4, 20	10
	}	30. Name and address of person who complete	eted cause of death (Item 2	(3a)	ــــــــــــــــــــــــــــــــــــــ			L	
		Pamela E. Southall, MD Ass	istant Medical Exam	niner 111 F	Penn Stree	t, Baltimo	re, MD 21201		
Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature	V.S					
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DHMH 17 Rev 1/20	91			ORIGINAL				001	T f Aug

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3^{Day} Physician/ 201**0**f August Raymond L. Witt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Brightview Assisted Living White Marsh If Under 1 Year If Under 24 Hrs Social Security Numbe . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Days Hours February 21°,1914 Maryland 212-01-6219 **Director** 96 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Kingsville 1 Yes 2 X No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21087 20 Elray Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) 12 College (1-4 or 5+) Captain Fire Prevention Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Maggie Klein Ahart Witt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Elray Road Kingsville, Maryland 21087 Mary Jane Schafer (Sister-in-law) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Joseph Church Cem 8/7/2010 Fullerton, MD 22 Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore, Maryland 21206 21. Signature of Funeral Service Licenses Disations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each tine. Approximate Interval Between Onset and Death 23a Part 1 Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician, Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death g ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 🗓 25. Was case referred to medical 26. Place of Death (Check only one. Hospital: 2 NO 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) LIVINK 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

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32. Registrer's Signature

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			1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)			2. Da	te of Death	Day Year	3. Time of Death
	nysicia Medic		Milton	Willia		09	3 DI	6 2010	850 AM
) E	xamin	er	4a. Facility Name (If not institution, give street and numb	11 .	4b. City, Town, or	Location of Death		4c. County of Death	
Fu	neral		5. Social Security Number 6. Sex 7.	Age (In yrs. last	birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Da	te of Birth onth, Day, Yes	N/A 9. Birthp	lace (State or Foreign
	ector		238-64-8161 ^{™ 2□ F}	71	Yrs. Months Days	Hours Min. (Min. 11	/27/1		ärolina
land			Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location			1	0d. Inside City Limits
Mary	ified a	żo	MD N/A		Baltimo	ore			1 kg Yes 2 □ No
ith the	o not	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	itry?
eath w	nust	Funeral	2500 Giles Road Apt.K	ent Ever in U.S.	21225			U.S.A. 14. Race - Americ	an Indian,
IIIQ Z I Z I 3-0030 be filed within 72 hours after death with the Maryland Hylgiene. A other than "patiral" or thans 33a or 38a,f show	niner	Fun	Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give	es?	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Specify Yon, Mexican, Puerto Rican, Specify:	etc.)	Black, White,	etc.
nours a	Exar	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date				4.0%		ack
10 72 t	edica	Completed	15. Decedent's Education (Specify only highest grade completed)		 Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired) 	tion uring most of working)	Dg	Kind of Business And AMAN S Bo	austry a L
d withigene.	the M	mo	6th Grade College (1-4		Cook			Gril	L
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hould d Men	matic	ဥ	Norman Williams 19a. Informant's Name/Relationship (Type. Print)		19b. Mailing Address (Street a	Peggie		Richards tv or Town, State, Zin	
nd 2 si	rtrau		Mia Gray(daughter)		2500 Giles				•
es 1 a of Hea	rothe		20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from Sta	20b. Place	e of Disposition (Name of etery crematory or other place of BLOWN T	Date		. Location - City or To	
DEMINITION WIND WAT YIELD SOUNDS After Geath with the Marylan Department of Health and Mertal Hygiene. The moorphant If the Marylan Marylan Hygiene. The Marylan Marylan Marylan Marylan Tria marked other than "natural" or Hence 29a or 28a4 show	jury o		4 ☐ Donation 5 ☐ Other (Specify)	And	Crematory	08/10/		altimore	
permit. Departr	any In		21. Signature of Funeral Service Licensee	Main		f. Brown Ji ulton Ave	r. Fur .,Balt	neral Hou cimore,MI	ne PA D 21217
11.5			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. [g, such as cardiac or resp	iratory arrest,		Approximate Interval Between
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oox outh cert	or use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birt	me pf pregnancy h 2 □ Fetal de				23d. Date of deliv	ery Day Year
The law requires that the death certificate has been signed by the attending	should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnar 9 ☐ Unknown 9 ☐ Unknown	nt at time of deat n	th 5 ☐ Other (specify)			17.07.11	,
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e law r	as De	Completed	Diabetes melitu	5			4a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
VILCII F Ician: The	ır, pag			Vascul	ar accident		performed ☐ Yes 21	No 1 Yes	2 □ No
yslcial	directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inp	patient 2 ☐ ER	VOutpatient 3 DOA Other	26. Place of Death (Che Pr: 4 Nursing Home		e 6 □Other (Speci	ify)
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LIVISION OF VITA To the Hospital or Attending Physician; within 24 hours a er death.	of the runeral chronol. Then this certificate has completely filled in by the funeral director, page 2:		29a. Certifier (Check only (C	is of examination	n and/or investigation, in my o	pinion, death occurred at	the time, date	and place, and due	to the cause(s)
o the lithin 2	omplet	Medical	one) and manne 29b. Signature and title of certifier	r stated.	29c. License	e number	29d	. Date signed (Month	, Day, Year)
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Λ.	1		and manne 29b. Signature and title of certifier 30. Name and address of person who completed cause 51e + 64 Cide W Te + 64 Cide W 31. Date filed (Month, Day Year) AGE 32. Reg	of death (Item 20	Sa) (Type, Print)	chipper Paa	(himo	re, MD 2	1230
41	Sta	to.	31. Date filed (Month, DavaYear) 32. Rec	jistrar's Simatur	e how les	- 1001 /11			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1430 M ZLEN WHITWER Month)R Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Severna Park 812 Creek View Road <u> Anne Arundel</u> 8. Date of Birth (Month, Day, Year July 3. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Hours Min. Director 505-54-6585 66 Kentúcky Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hydiene. 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Severna Park 1 Tes 2 No Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 812 Creek View Road 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? 1967 Black, White, etc. 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 1970 Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than ' College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Business Consultant Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gladys Musser Glen S. Whitwer Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 812 Creek View Road Severna Park, MD 21146 Betty R. Whitwer, Wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/09/10 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licen Cremation Society Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition a Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? After this certificate 1 Yes 2 No Yes completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2- No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign: V1438 son who completed cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar's Si

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Edward August Watson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Regional Hospita trince George dure 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Months Days Hours Min Director 216-42-5766 63 **1946** Tennessee Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f sho 10c, City, Town or Location 10d. Inside City Limits Director MD Howard Jessup 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral House of Correction Road 20794 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Professional Painter Painting other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Earl Watson Haze1 Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra L. Yost, sister 11406 Spicewood Parkway Austin, Texas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 08/06/10 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ancenoma disease or condition resulting in death) weeks Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate sause. Enter or denying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day ☐ Pregnant at time of death
☐ Unknown 9 Unknown certificate has been signed by irector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 M No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 \Box 2 \Box No. 5 Pending ☐ Accident neral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier 🛂 Certifylng Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number August 4 D 24283 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13631 Bal imore 31. Date lied (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No 2 1 1 2 1 0 0											01.000	
		1	Registrar 1. Decedent's Name (First, Middle, Last)							Reg. No 2 0 0 2 4 9 9 9 2. Date of Death 3. Time of Death				
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4			Ridgeway Mano	r Nursi	ng & l	Rehab	Baltin							
Fune			,	6. Sex 1 □ M 2 😾 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	th y, Year)	Coui		
Direc	tor		S14-18-5042 Usual Residence of Decedent	24	107	113.				9/8/19	902	Ita.	Ly	
yland	N	-	0a. State 10b. County		10c. Cit	y, Town or Loc	cation	-	10d. Inside City				0d. Inside City Limits	
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death with the Maryland ms 23a or 28a-f show	2	2 1	10e. Street and Number 10f. Zip Code								10g. Citizen of	What Cour	ntry?	
s 23a		<u>a</u>	5743 Edmondso				21228				USA			
ter de		Funeral Director	11. Marital Status 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Yes □ □ □ No			If Yes, specify Cuban, Mexican, Puerto			gin? (Spe i, Puerto	ecity Yes or No Rican, etc.)		14. Race - American Indian, Black, White, etc.		
USC urs af al", or		2	3 Widowed 4 □ Divorced	If Yes, Giv Year or Da	0	1 ☐ Yes 2 🙀 No Specify:				-	Speci	Specify: White		
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ithin han "			Elementary/Secondary (0-12) College (1-4or 5+)			1	(Give kind of work done during most of workin life. DO NOT use retired) Inspector				Americ	ican Can Co		
Hygie	3		7. Father's Name (First, Middle, La	ect)		Tusp	ecror	18 Motho	ar'e Nama	/First Middle	Maiden Surna	me)		
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IOTE, INALYIATIO ZIZID-UUJO ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If them 271s marked of their than "natural", or items 23a or 28a-f show	F		9a. Informant's Name/Relationshi	o (Type. Print)	on.	19b. Mailin	g Address (Street				er, City or Towi	n, State, Zip	Code)	
y Michael 2 and 2 salth a 127 is	5		Franklin Llo	31	J11	7852	St. Cl	aire	Laı	ne, Ba	ltimor	e,MD	21222	
of He		2	0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		11010	Place of Dispos emetery, crem	sition (Name of natory or other plac	e)		Date	20c. Location	- City or To	own, State	
Pag tment tant:	À		4 Donation 5 Other (Spe		Sa	cred	Hrt.Jes	us 8	-11-	-2010	Baltin	ore,	MD	
paritinore, many permit. Pages 1 and 2 Department of Health & Important: If them 27 is any injury or other free	once.	2	1. Signature of Funeral Service Li			22	. Name and Addres	ss of Facility	Jos	seph N	. Zanr	nino	Jr. FH	
_ 40=	5 01	1	263 S. Conkling St. Baltimore, MD 21224											
		- 1	23a. Part 1. Enter the disease to complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on pause on each line. Approximate Interval Between Onset and Death											
- Physici /Medic	_		disease or condition esulting in death)	- Le	neu	to						- (PRORS	
Examin				Livide to (c	or as a consequ	uence on:								
	i i	if S	Sequentially list conditions, any, leading to immediate	uence of):	,					1	-			
ecuted and transi		E ti	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence)											
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death death e atte	100	2 2	23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of dea				death 3 Ectopic pregnancy					Month Day Year		
at the de lby the		2	9 Unknown											
res tha signed be det	Ž		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
w requir s been s should	100		the petersion							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
e law has b		_	Mooropatue four.							autor	24a. Was an autopsy findings availab prior to completion of cause o			
Physician: The la rthis certificate has rall director, page 2	֟ <u></u>		on teoaction bes					po 1 □ Ye				erformed? death? s 2 No 1 Yes 2 No		
Siciar certification	a a	2	 Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 	Hospital:			Othe	nr:		(Check only o				
ding Phy h. After this	12		7. Manne of Death	3 LI DOA	J DOA 4 La Prairing Home			5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred						
ath. Fr: After efunding	Certification.		1 Natural 5 Pending 2 Accident investigat	Injury	/ Work? M 1 □Yes 2 □No									
er degree rector	iji	Š	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, to building, etc. (Specify)				farm, street, factory, office 2			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ital or ral Dia fed in Fed in	و													
Hospital or Attending Physician: The law requires that the death certificate be executed thus after death. Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit	polical	2	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
To the Hospital or Attendition 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med		one) and manner stated. 29b. Signature and title of certifier					29c. License number				29d. Date signed (Month, Day, Year)		
F S F O							D(366)				08-09-2010			
10		30	D. Name and aderess of person wi											
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	State istrar		1. Date filed (Month, Day, Year) AUG 1 0 201	32. Re	gistrar's Signa	bark	1							
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

Reg. No. 20 For State Registrar 25000 3. Time of Death 8:40a 1. Decedent's Name (First, Middle, Last) 2. Date of Death J也數 23 pa 2010 Year Abdelnour J. Physician Yasmine /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Palestine 578-86-6758 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experies must be resisted encourse. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County MD Takoma Park Montgomery 1XYes 2□No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20912 USA 8506 Barron Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: If Yes, Give Year or Dates: Specify: ρ 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Victoria Totah 17. Father's Name (First, Middle, Last) Be Khalil Sheikh ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8506 Barron Street Takoma Park, Md. 20912 19a. Informant's Name/Relationship (Type. Print) Anees Abdelnour/Son 20b. Place of Disposition (Name of cemetery, crematory of other place)

George Washington 7/27/2010 Adelphi, Md 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) PHILE TO PADOR SERVICE, P.A. 21. Signature of Funeral Service Lice 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a or Attending Physician: The law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burlal-tran Division of Vital Records, P.O. Box 68769 resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death/but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed 1 🗷 Yes 2 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 117Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 XNatural 5 Pending death. investigation 1 ☐Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7701 Carroll Avenue Takoma Park, Md 20912 Nasreen Kango MD 31. Date filed (Month, Day, Year) Registrar's Signature State 27 2010 Registrar